NHS Fife Clinical Governance Committee

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

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Arlene Wood

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Arlene Wood

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Friday 13 January 2023

Enclosed *Arlene Wood*

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20230112.pdf (11 pages)

10:00 - 10:15
15 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 04 - Clinical Governance Committee Action List - 20230303.pdf (2 pages)

4.1. Healthcare Improvement Scotland (HIS) Inspection

Enclosed *Claire Dobson*

Item 04.1 - SBAR Healthcare Improvement Scotland (HIS) Inspection.pdf (6 pages)
Item 04.1 - Appendix 1 Summary of HIS Acute Inspections.pdf (7 pages)
Item 04.1 - Appendix 2 HIS Letter November 2022.pdf (2 pages)

4.2. Resilience Assurance Update

Enclosed *Joy Tomlinson*

Item 04.2 - SBAR Resilience Assurance Update.pdf (6 pages)

10:15 - 10:15
0 min

5. ACTIVE OR EMERGING ISSUES

None

10:15 - 10:45
30 min

6. GOVERNANCE MATTERS

6.1. Committee Self-Assessment Report 2022/23

Enclosed *Gillian MacIntosh*

Item 06.1 - SBAR Committee Self-Assessment Report 2022-23.pdf (13 pages)

6.2. Annual Review of Committee's Terms of Reference

Enclosed *Gillian MacIntosh*

Item 06.2 - SBAR Annual Review of Committee's Terms of Reference.pdf (3 pages)
Item 06.2 - Appendix 1 Committee's Terms of Reference.pdf (4 pages)

6.3. Corporate Risks Aligned to Clinical Governance Committee

Enclosed *Chris McKenna/Janette Owen*

Item 06.3 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (6 pages)
Item 06.3 - Appendix 1 Summary of Corporate Risks Aligned to the Clinical Governance Committee.pdf (5 pages)
Item 06.3 - Appendix 2 COVID19 Pandemic Deep Dive Review.pdf (3 pages)
Item 06.3 - Appendix 3 Assurance Principles.pdf (1 pages)

6.3.1. Deep Dive - Covid-19 Pandemic

Joy Tomlinson

10:45 - 11:20
35 min

7. STRATEGY / PLANNING

7.1. Draft Population Health & Wellbeing Strategy

Enclosed *Margo McGurk/Susan Fraser*

Item 07.1 - SBAR Population Health & Wellbeing Strategy + Appendix 1.pdf (7 pages)
Item 07.1 - Appendix 2 Draft Population Health & Wellbeing Strategy.pdf (33 pages)

7.2. Strategic Planning & Resource Allocation 2023/24

Enclosed *Margo McGurk*

Item 07.2 - SBAR Strategic Planning & Resource Allocation 2023-24.pdf (6 pages)

7.3. Cancer Framework and Delivery Plan

Enclosed *Chris McKenna/Shirley-Anne Savage*

Item 07.3 - SBAR Cancer Framework and Delivery Plan.pdf (5 pages)
Item 07.3 - Appendix 1i Cancer Actions Overview.pdf (6 pages)
Item 07.3 - Appendix 1ii Cancer Actions Overview.pdf (1 pages)
Item 07.3 - Appendix 2 Cancer Annual Delivery Plan.pdf (12 pages)

11:20 - 11:55
35 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance & Quality Report

Enclosed *Chris McKenna/Janette Keenan*

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

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

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

8.3. NHS Fife Response to the Ockenden Report

Enclosed *Janette Keenan*

Item 08.3 - SBAR NHS Fife Response to the Ockenden Report.pdf (22 pages)

8.4. National Treatment Centre - Fife Orthopaedics

Enclosed *Janette Keenan*

Item 08.4 - SBAR National Treatment Centre - Fife Orthopaedics.pdf (4 pages)

11:55 - 12:05
10 min

9. DIGITAL / INFORMATION

9.1. Information Governance and Security Steering Group Update

Enclosed *Alistair Graham*

Item 09.1 - SBAR Information Governance and Security Steering Group Update.pdf (8 pages)

12:05 - 12:15
10 min

10. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1. Patient Experience & Feedback Report - Quarter 3

Enclosed *Janette Keenan*

Item 10.1 - SBAR Patient Experience and Feedback report + Appendix 1.pdf (16 pages)
Item 10.1 - Appendix 2 Patient Experience & Feedback Quarterly Report.pdf (17 pages)

12:15 - 12:30
15 min

11. ANNUAL REPORTS

11.1. Organisational Duty of Candour Annual Report

Enclosed *Chris McKenna*

Item 11.1 - SBAR Organisational Duty of Candour Annual Report.pdf (4 pages)
Item 11.1 - Appendix 1 Draft Organisational Duty of Candour Annual Report 2021-2022.pdf (21 pages)

11.2. Annual Review of Deaths of Children & Young People

Enclosed *Janette Keenan/Shirley-Anne Savage*

Item 11.2 - SBAR Annual Child Death Review Report 2022.pdf (3 pages)
Item 11.2 - Appendix 1 Annual Fife Partnership Review of Children and Young People Deaths 2022.pdf (9 pages)

12:30 - 12:40
10 min

12. FOR ASSURANCE

12.1. Delivery of Annual Workplan 2022/23

Enclosed *Shirley-Anne Savage*

Item 12.1 - Delivery of Annual Workplan 2022-23.pdf (8 pages)

12.2. Annual Clinical Governance Committee Workplan 2023/24

Enclosed *Shirley-Anne Savage*

Item 12.2 - SBAR Annual Clinical Governance Committee Workplan 2023-24.pdf (3 pages)
Item 12.2 - Appendix 1 Annual Clinical Governance Workplan 2023-24.pdf (7 pages)

12:40 - 12:45
5 min

13. LINKED COMMITTEE MINUTES

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

Enclosed

- Item 13.1 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.1 - Area Clinical Forum Minutes 20230202 (unconfirmed).pdf (4 pages)

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

Enclosed

- Item 13.2 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.2 - Area Medical Committee Minutes 20221213 (unconfirmed).pdf (7 pages)

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

Enclosed

- Item 13.3 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.3 - Cancer Governance & Strategy Group Minutes 20230113 (unconfirmed).pdf (8 pages)

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

Enclosed

- Item 13.4 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.4 - Clinical Governance Oversight Group Minutes 20221220 (confirmed).pdf (8 pages)

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

Enclosed

- Item 13.5 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.5 - Digital & Information Board 20230124 (unconfirmed).pdf (7 pages)

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

Enclosed

- Item 13.6 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.6 - Fife Drugs & Therapeutic Committee Minutes 20230208 (unconfirmed).pdf (7 pages)

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

Enclosed

- Item 13.7i - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.7i - Fife IJB Quality & Communities Committee 20221108 (unconfirmed).pdf (8 pages)
- Item 13.7ii - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.7ii - Fife IJB Quality & Communities Committee 20230118 (unconfirmed).pdf (4 pages)

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

Enclosed

- Item 13.8 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.8 - Health & Safety Subcommittee 20230120 (unconfirmed).pdf (10 pages)

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

Enclosed

- Item 13.9 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.9 - Information Governance & Security Steering Group 20230131 (unconfirmed).pdf (5 pages)

13.10. Resilience Forum held on 1 December 2022 (unconfirmed)

Enclosed

- Item 13.10 - Linked Minute Cover Paper.pdf (1 pages)
- Item 13.10 - Resilience Forum Minutes 20231201 (unconfirmed).pdf (5 pages)

12:45 - 12:50
5 min

14. ESCALATION OF ISSUES TO NHS FIFE BOARD

14.1. To the Board in the IPQR Summary

Verbal *Arlene Wood*

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

Verbal *Arlene Wood*

12:50 - 12:50
0 min

15. ANY OTHER BUSINESS

12:50 - 12:50
0 min

16. DATE OF NEXT MEETING - FRIDAY 5 MAY 2023 AT 10AM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 13 JANUARY 2023 AT 10AM VIA MS TEAMS

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

In Attendance:
Norma Beveridge, Head of Nursing
Jo Bowden, Consultant in Palliative Medicine *(item 8.5 only)*
Nicky Connor, Director of Health & Social Care
Claire Dobson, Director of Acute Services
Susan Fraser, Associate Director of Planning & Performance
Alistair Graham, Associate Director of Digital & Information
Ben Hannan, Director of Pharmacy & Medicines
Helen Hellewell, Associate Medical Director
Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy *(part)*
Elizabeth Muir, Clinical Effectiveness Manager
Shirley-Anne Savage, Associate Director of Quality and Clinical Governance
Karen Wright, Clinical Services Manager *(item 8.5 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

In addition, the Chair acknowledged the unprecedented Winter pressures, and the dedication and work of all our staff in providing safe care in extenuating circumstances.

The Chair advised that the meeting is being recorded for the purpose of the Minutes.

1. Apologies for Absence

Apologies were received from attendees Iain MacLeod (Deputy Medical Director) and John Morrice (Consultant Paediatrician and Associate Medical Director).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 4 November 2022

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

4. Matters Arising / Action List

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

4.1 Inequalities and Adverse Events Action

The Director of Public Health provided background to this action and reported that that the action is still in progress due to the recruitment of a new Equality & Human Rights Lead, who is now in post.

The Medical Director noted that the data would not be reported regularly through the Integrated Performance & Quality Report, however, findings would be provided to the Committee in due course.

5. ACTIVE OR EMERGING ISSUES

5.1 Covid-19

The Director of Public Health provided a verbal update and reported that the Office for National Statistics (ONS) survey data has estimated that 1 in 25 of the population currently have Covid and that we have now reached the peak of the new variant. It was noted the survey reports on a weekly basis.

It was also reported that respiratory illness was at high levels across the system, and that this has now moved back to moderate levels.

The Director of Public Health was pleased to advise that there has been a positive uptake of the Covid & Flu vaccinations, and that targets have been met for both.

It was noted national communications for Winter planning has been supplemented with local messages from Directors.

The Medical Director highlighted that this item has been a standing agenda item since the start of the Covid pandemic, as an active issue. It was agreed that it now be removed as a standing item and any significant issues would be brought back to the Committee as a written report.

The Committee **noted** the update.

6. GOVERNANCE MATTERS

6.1 Corporate Risks Aligned to Clinical Governance Committee

The Medical Director advised that our profile, in terms of corporate risks aligned to the Clinical Governance Committee, is unchanged since the previous Committee meeting. It was noted that deep dives will enable detailed discussions on specific risks at Committee meetings. Feedback on the presentation of deep dives was welcomed, and the presentation will be reviewed for future meetings. It was highlighted that corporate risks across all areas are integrated, and that this should be clear in the presentations for discussion.

For consistency, progress on any actions for each corporate risk aligned to the Clinical Governance Committee was requested as a visual.

Action: Risk Manager

An update was provided on next steps for the Corporate Risk Register, and the Director of Finance & Strategy advised that further work to enhance, develop and present the corporate risks to the Board Committees is being led by the Risk & Opportunities Group, and support has also been offered from A Wood, Committee Chair. It was noted that a discussion on risks had taken place with new Non-Executive Members to identify any additional information that may be required in the Corporate Risk Register to provide assurance. The Director of Finance & Strategy highlighted that the majority of corporate risks are currently operating outwith our risk appetite, and that definitive statements will be required to be provided to the Board and Committees in relation to tolerating specific levels of risks.

It was agreed to prioritise the deep dives as follows:

- Covid-19 Pandemic
- Optimal Clinical Outcomes
- Quality & Safety
- Off-Site Area Sterilisation and Disinfection Unit Service
- Cyber Resilience

The workplan will be updated.

Action: Board Committee Support Officer

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

6.1.1 Deep Dive - Digital & Information

The Associate Director of Digital & Information noted that reliance on digital systems is key to supporting our clinical services. An overview on the root causes and actions for the digital & information risk was provided, as detailed in the paper. It was noted this risk continues to be high, and that the action plan will support reducing the level of risk.

K MacDonald, Non-Executive Whistleblowing Champion requested that the digital & information risk is clearly linked to improving quality & health within the strategic priority section. The Director of Finance & Strategy highlighted that to deliver value and sustainability, this relates to sustainability of service, and is not solely on the financial aspect.

7 STRATEGY / PLANNING

7.1 Population Health & Wellbeing Strategy

The Director of Finance & Strategy introduced this item and advised that discussions are ongoing to build the content of the strategy. It was advised that a first draft of the strategy was presented to the Portfolio Board held on 12 January 2023, and it will also be presented to the Board Development Session in February 2023 for a focussed discussion on progress of the detail.

It was reported that significant progress has been made in concluding the engagement work and feedback from the external company is expected in mid-January 2023. The Associate Director of Planning & Performance reported that the content of the strategy document has been prepared and influenced by all the Directors, who have been working on developing and drafting the strategy within their own areas. Further work will take place and the strategy document will be brought to the March 2023 Board and Committee meetings. It was noted that the strategy will be public facing, and work will be carried out to ensure the document is appealing to the population.

The Medical Director questioned if the detail within the strategy will be bold and explicit in terms of the difficulty of recovery of healthcare systems in the coming years. The importance of the delivery plan was highlighted.

The Chair questioned if clinical responses, in terms of elements from the Clinical Strategy, will be incorporated into the Population Health & Wellbeing Strategy. The Director of Finance & Strategy provided assurance that the Population Health & Wellbeing Strategy links to the delivery plans and programmes in place within NHS Fife.

The Director of Finance & Strategy raised concern for the financial sustainability and advised that difficult decisions will need to be made.

It was noted the strategy milestone plan is on track.

The Committee took **assurance** on the progress of the strategy through the contents of this report.

7.2 Cancer Framework & Delivery Plan

The Medical Director noted that the framework and delivery plan had been presented to the Committee previously in draft format and has been brought back to the Committee today in final version for agreement (with the caveat that final proof reading will be carried out before publishing). It was noted that this is the first time NHS Fife has had a Cancer Framework. The Cancer Framework will sit within, and support, the Population Health & Wellbeing strategy.

A Haston, Non-Executive Member highlighted that workforce would need to be reviewed to ensure future service delivery and questioned how specific training needs would be identified and addressed. The Director of Nursing highlighted challenges with training due to recruitment and advised that discussions are taking place regionally. The Director of Pharmacy & Medicines advised that cancer treatment is the fastest growing area for medicines and that different models of training are required, noting that this will also form part of the workforce strategy and is an evolving

piece of work. The Associate Director of Quality & Clinical Governance reported that the Scottish Government has requested a Fife staffing plan for future chemotherapy systemic-anti cancer therapies (SACT) delivery. A plan has been developed, but funding is not yet available. It was noted a Cancer Nurse Educator post was part of the plan and would support the training.

The Medical Director also highlighted a concern around sustainability in terms of medical staffing including oncologists and noted that Fife work closely with NHS Lothian colleagues and the Cancer Network in terms of this staffing.

The Chair queried progress against the delivery plan 2022/23, and the process around setting priorities for 2023/24. The Medical Director replied that an annual update on the delivery plan will go to the Cancer & Governance Strategy Group before being presented to the Committee. It was confirmed delivery plans are developed for each year, with new priorities set.

The Medical Director thanked Kathy Nicoll and team for their hard work.

The Committee **approved** the Cancer Framework and Delivery Plan.

7.3 Clinical Governance Framework & Delivery Plan

The Medical Director reported that the Clinical Governance Framework is presented in its final version with the caveat that final proof reading will be carried out.

S Fevre, Area Partnership Forum Representative highlighted the importance of an ongoing communication plan to staff. The Medical Director noted that the support of S Fevre and other staff side colleagues will be pivotal to ensure the document is well received by staff. S Fevre suggesting speaking to staff on face-to-face may be better received.

The Medical Director thanked the team for all their hard work.

The Committee **approved** the Clinical Governance Framework & Delivery Plan 2022/23

8 QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report

The Director of Nursing spoke to the report and highlighted a reduction in the number of falls, noting it is expected the reduction target will be met this year.

An overview on pressure ulcers was provided noting that the rate of pressure ulcers continues to vary.

In terms of infection control, it was reported that NHS Fife is doing well in this area, achieved through enhanced surveillance. An update was provided on C Diff, and it was highlighted that NHS Fife has the lowest infection rate of all mainland Health Boards, which has been achieved through strong antimicrobial stewardship. Challenges in meeting the ECB target were outlined, as detailed in the paper.

The Director of Nursing advised that complaints continue to be challenging, however, there has been a significant improvement in the number of complaints being closed off each month, and open complaint numbers have reduced. It was reported that additional staff have been recruited into the Patient Experience Team.

A Haston, Non-Executive Member requested more detail on the work being done to address urinary catheter related infections. In response, it was advised that discussions are taking place with our microbiologists, medical and nursing staff around addressing the issue and looking at lessons learned.

Following questions from A Lawrie, Area Clinical Forum Representative, it was advised that the establishment gap is still a work in progress and updates will be provided through the Staff Governance Committee. The Medical Director noted that there is a lot of work being carried out in relation to adverse events and looking at innovative ways to support teams.

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

8.2 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing advised there has been no unannounced inspections from Healthcare Improvement Scotland (HIS) and they have temporarily paused inspections due to the current system pressures. It was advised that preparation work has been carried out in relation to mental health hospitals, and a large amount of work has been carried out for the safe delivery of care inspections.

The Director of Nursing reported that bays had been closed due to norovirus and seasonal influenza.

In terms of cleaning and healthcare environment, it was reported that the standard is 90% for the overall cleaning compliance with NHS Fife reaching 96%, which is positive.

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

8.3 NHS Fife Response to the Letter from Health Improvement Scotland (HIS)

The Medical Director advised that a response has been prepared to the letter from HIS describing the supporting activities that are being undertaken in Fife to mitigate against some of the areas of concern. The Chief Executive added that the paper includes mitigations against risks.

It was advised that the paper will go to the Executive Directors' Group at their meeting on 19 January 2023, before being shared with the Committee for assurance on our commitment to patient safety.

The Director of Acute Services noted that it has been a particularly challenging time due to significant overcrowding in the Emergency Department and lessons have been learned. S Fevre, Area Partnership Forum Representative commented that staff are living through the issues outlined in the letter.

The Committee **noted** the letter and took **assurance** that there is a plan being devised and will be presented to the Committee in due course.

8.4 High Risk Pain Medicines Patient Safety Programme – Year One Update

The Director of Pharmacy & Medicines advised that this item was discussed at the Public Health & Wellbeing Committee on 11 January 2022, as there is a Public Health and overall strategy component of the programme
The Director of Pharmacy & Medicines spoke to paper and highlighted the main points. It was noted year one has been mainly around identifying the problem and year two will focus on ingests of change.

The Medical Director highlighted the significant issues and risk around high-risk pain medicines due to delays in planned treatments due to the Covid pandemic.

The Committee took **assurance** from the Year One delivery of the HRPM Patient Safety Programme.

8.5 Fife Specialist Palliative Care Services - Service Model Presentation

The Consultant in Palliative Medicine presented on the Fife Specialist Palliative Care Services. The presentation will be shared with the Committee.

Action: Board Committee Support Officer

The Director of Health & Social Care advised that the decision making route for this service will be through the Integration Joint Board, and that clinical governance and quality aspects will come through this Committee.

A Haston, Non-Executive Member requested clarity on risks. It was advised that no active risks have been detailed, as the service was a requirement of the response to the pandemic, and that what was set out to be delivered is being achieved. It was noted that the challenge is the growing need for the service and expansion. The next steps were outlined. The Clinical Services Manager added that work has been carried out to determine the optimal service model along with staffing requirements to sustain the service. Opportunities for training and development are being explored and it was noted there is no financial risk at this time.

The Consultant in Palliative Medicine explained that there is a large scale of unmet palliative care needs in all care settings across the sectors, and that work is being carried out with other delivery partners to ensure families and individuals can receive the support they need.

The Committee thanked the Consultant in Palliative Medicine and Clinical Services Manager for their presentation.

The Committee **supported** the new service outreach delivery model.

9 DIGITAL / INFORMATION

9.1 Update on Digital Strategy 2019-2024

The Associate Director of Digital & Information spoke to the report which details the challenges, alterations, and successes of implementation of our digital strategy, which was endorsed by the Board in September 2020. It was reported the strategy is aligned to the Population Health & Wellbeing Strategy.

The Committee:

- **Noted** the delays in progress to the TrakCare and Clinical Portal improvement work due the prioritisation of the LIMS project and the impact from suppliers on the ability to deliver the strategy in a timely manner
- Took **assurance** of the progress for the Digital and Information Strategy - 2019-2024.

9.2 Records Management Plan - National Registers of Scotland Keeper's Report

The Associate Director of Digital & Information spoke to the report noting it outlines the records management plan, particularly around patient records and that it also sets out the governance arrangements.

The Medical Director highlighted the importance of records management.

The Committee **considered** that the Keeper's report provides **assurance**, and the governance arrangements for implementing the Records Management Plan are adequate.

10 PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1 Patient Experience & Feedback Report

The Director of Nursing reported an improving position around the closure of stage 2 complaints and advised that the paper sets out more detail on progress of each complaint. It was advised that this detail is shared on a weekly basis with services and teams. It was also highlighted that work is ongoing to stratify the table of complaints, as some complaints require input from specific areas where the likelihood of responding will not meet the 20-day target.

The Committee acknowledged the ongoing pressures associated with closing complaints within the 20-day standard and took assurance from the ongoing work to address this.

The Committee took **assurance** from the Patient Experience & Feedback Report.

11 ANNUAL REPORTS

11.1 Equality Outcomes and Mainstreaming Interim Report 2021-2023

The Director of Nursing spoke to the report and highlighted the progress made towards each of the specified equality outcomes. It was advised that discussions are taking place through a Board Development Session on improving and embedding knowledge & skills through learning, mentoring and leadership.

S Fevre, Area Partnership Forum Representative commented that further work is required in terms of improvements to equality, and it should be extended wider than through the Black, Asian and minority ethnic (BAME) Network. The Director of Nursing advised that an Equalities and Human Rights Lead is now post, and that a refresh of the Equalities & Human Rights Strategic Group is being carried out, with the first meeting scheduled for February 2023.

The Chair welcomed the report and asked if progress and outcomes against health inequalities in section 4 could be incorporated into the report.

Action: Director of Public Health

The Committee:

- Took **assurance** that the report details NHS Fife's mainstreaming activity and how we intend to continue to make progress against these actions for the next two years;
- **Considered** the content of report; and
- **Agreed** to publish the Interim Report by 31 March 2023

11.2 Research & Development (R&D) Strategy Review 2021/2022 and Research, Innovation and Knowledge (RIK)Strategy 2022-2025

The Medical Director advised that the strategy sets out the ambitions and priorities for research, innovation and knowledge.

It was agreed a Development Session is to be arranged this year and the Medical Director suggested an area of focus would be the research relationship between NHS Fife and the University of St Andrews.

Action: Board Committee Support Officer

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

11.3 Research, Innovation & Knowledge Annual Report 2021/2022

The Medical Director advised that the Annual Report sets out activity that has been carried out throughout 2021/22.

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

12. FOR ASSURANCE

12.1 Delivery of Annual Workplan

The Associate Director of Quality & Clinical Governance agreed to confirm a timeline for the Resilience Annual Report coming to Committee. The Board Secretary advised it had been agreed a position statement would be provided before year-end, until the Annual Report has been concluded.

Action: Associate Director of Quality & Clinical Governance

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

12.2 Proposed Annual Workplan 2023/2024

The Associate Director of Quality & Clinical Governance welcomed any additions to the proposed workplan for 2023/24 and advised a final version will be brought back to the Committee at the March 2023 meeting for final approval.

The Committee:

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

13. LINKED COMMITTEE MINUTES

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

13.1 Acute Services Division Clinical Governance Committee held on 16 November 2022 (unconfirmed)

- The Medical Director advised that formal recognition has been provided through the escalation paper for Acute Services Division Clinical Governance Committee in relation to reigniting the work that had previously existed in relation to deteriorating patients. It was noted the cover paper from the Clinical Governance Oversight Group details the same point.

- The Medical Director noted that the Acute Services Division Clinical Governance Committee minutes link into the Clinical Governance Oversight Group and can therefore be removed from the Clinical Governance Committee workplan.

Action: Board Committee Support Officer

13.2 Area Clinical Forum held on 1 December 2022 (unconfirmed)

- The Medical Director noted the pressures and demands on General Practitioners and the sustainability of staffing longer term. It was agreed assurance will be provided to the Area Clinical Forum that the Clinical Governance Committee are aware of the pressures within General Practice. The Medical Director reported that the Primary Care Strategic Plan was discussed at the Public Health & Wellbeing Committee, where it was agreed that the majority of primary care issues will go through this Committee.

13.3 Area Medical Committee held on 11 October 2022 (unconfirmed)

13.4 Cancer Governance & Strategy Group held on 19 August 2022 (confirmed) & 4 November 2022 (unconfirmed)

- The Medical Director advised that the cover paper from the Cancer Strategy Group is not an escalation and is for information only.

13.5 Clinical Governance Oversight Group held on 18 October 2022 (confirmed)

13.6 Fife Drugs & Therapeutic Committee held on 7 December 2022 (unconfirmed)

13.7 Infection Control Committee held on 5 October 2022 (confirmed) & 7 December 2022 (unconfirmed)

13.8 Information Governance & Security Steering Group held on 11 October 2022 (unconfirmed)

13.9 Research, Innovation & Knowledge Oversight Group held on 14 December 2022 (unconfirmed)

The Chair and Medical Director agreed to discuss preparing responses to the various groups outwith the meeting.

Chair/Medical Director

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

It was agreed to escalate for assurance, the Cancer Framework and Clinical Governance Framework, to the Board at their January 2023 meeting. (Post meeting, it was agreed both topics would be scheduled for the March Board meeting).

15. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 3 March 2023 at 10am via MS Teams.

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 3 March 2023

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	01/07/22	**IPQR**	To take forward as an action whether the data within our existing statistics could be analysed further to give a better understanding of inequalities and adverse events and if there are any patterns.	**JK**	Extended to May 2023	In progress. The Lead for Adverse Events is taking this action forward and has arranged a meeting with the Equality & Human Rights Lead Officer. 15/02/23 - The current data collected within the Adverse Events reporting system does not cover a wide range of inequalities. Meeting will explore potential for further analysis of existing data and potential for capturing additional information.	In progress
2.	12/01/23	**Development Session**	A Development Session to be arranged on the research relationship between NHS Fife and the University of St Andrews.	**HT**	A future Development Session in 2023		In progress
3.	12/01/23	**Resilience Annual Report**	To provide a position statement before year-end, until the Annual Report has been concluded.	**SAS**	March 2023	On agenda under matters arising.	Closed
4.	04/11/22	**Medical Education**	To liaise with the team regarding presenting at a future Committee Development Session on Medical Education	**CM/HT**	A future Development Session	Development Session arranged for 12 April 2022. Both Medical Education and Addiction Services are the two topics.	Closed
5.	02/09/22	**Addiction Services**	To liaise with the team regarding presenting at a future Committee Development Session on Addiction Services.	**LB/HT**			

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
6.	12/01/23	**Corporate Risks Aligned to Clinical Governance Committee**	Progress on any actions for each corporate risk aligned to the Clinical Governance Committee to be brought back as a visual.	**PC**	Future meetings	10/02/23 - MM discussed with CMcK and they agreed we will continue to work with the new risk report rather than prepare a different set of slides for this committee.	Closed
7.	12/01/23	**Linked Committee Minutes**	The Chair and Medical Director agreed to discuss preparing responses to the various groups outwith the meeting.	**AW/CM**	February 2023	10/02/23 – completed. Responses issued.	Closed
8.	12/01/23	**Equality Outcomes and Mainstreaming Interim Report 2021-2023**	To incorporate progress and outcomes against health inequalities into the final 2025 report.	**JK**	2025	JK has ensured that the final report (March 2025) will encompass progress against health inequalities.	Closed
9.	12/01/23	**Workplan**	To remove the Acute Services Division Clinical Governance Committee minutes from the workplan.	**HT**	January 2023	23/01/23 – completed.	Closed
10.	12/01/23	**Fife Specialist Palliative Care Services - Service Model Presentation**	To share the presentation.	**HT**	January 2023	23/01/23 – circulated.	Closed
11.	12/01/23	**Deep Dives**	To update the workplan with the agreed prioritisation of deep dives.	**HT**	March 2023	23/01/23 – completed.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Healthcare Improvement Scotland (HIS) Inspection**
Responsible Executive:	**Claire Dobson, Director of Acute Services**
Report Author:	**Iain Macleod, Deputy Medical Director (Acute)**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Assurance

This report relates to:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Healthcare Improvement Scotland (HIS) Director of Quality Assurance wrote to all NHS Scotland Boards on 22 November 2022 (Appendix 1) to highlight concerns raised via recent Safe Delivery of Care Inspections of acute hospitals. The Acute Services Division (ASD) considered the concern and guidance shared via the letter regarding the aspects of safety and quality highlighted to ensure that the learning was acted upon. The ASD Senior Leadership Team has reviewed practice, policies and procedures to assure NHS Fife of learning regarding the issues highlighted in the letter in relation to the impact that ongoing system pressures are having on acute care delivery.

2.2 Background

Since the beginning of 2021, HIS has been carrying out COVID-focused inspections of acute hospitals, using methodology adapted from its previous ‘safe and clean’ inspections. The Victoria Hospital Kirkcaldy (VHK) was inspected in May 2021 which resulted in 7 areas of good practice and 2 requirements.

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

To provide targeted assurance on the safe delivery of care in the context of current service pressures these inspections are focussing on:

- Standard infection control precautions and transmission-based precautions for infection prevention and control
- COVID-19 and/or the use of respiratory pathways. The pathways are routes that patients should follow during their stay in hospital to minimise the risk of infection transmission
- Key indications of the delivery of care such as personal care, fluid and nutrition
- Management of safety and risk through observation of care, attendance at hospital safety huddles and assessment of staffing data provided by the NHS board.

To date, 8 inspections have been carried out in acute hospitals across 7 Boards (2 inspections have been carried out in NHS Forth Valley Appendix 1).

In April 2022 HIS wrote to alert Boards of serious safety risks that had been identified in their initial Safe Delivery of Care Acute Hospital Inspections. The ASD at that time considered these and sought to ensure that learning was shared and acted on.

Maintaining safety and delivering effective quality care continue to be core to ASD planning and decision making. On receipt of the HIS November letter the ASD Senior Leadership Team reflected on the areas highlighted and reviewed systems and procedures, as recommended, to ensure that the risks and issues highlighted were being robustly considered and teams were being supported to manage and address them.

2.3 Assessment

The sustained capacity pressures across the ASD and increased demand creates a number of clinical challenges in maintaining safety on site. This, at times of extremis, results in ambulances queuing outside of the ED and a delay in patients being handed over to the ED team. The impact of this includes safety concerns for patients and staff and, also results in ambulances not being able to respond to emergency calls in the community.

Should this situation arise an escalation call to the site capacity team and onwards to the General Manager of the day would be immediately triggered. This would initiate the Patient Cohorting – Ambulance Waits Standard Operating procedure, which is a whole site response to accommodating those patients what are waiting to enter the ED.

Oversight and supportive leadership

Earlier this year NHS Fife introduced an Operational Pressures Escalation Levels Framework (OPEL), as a clear and agreed system wide overview mechanism to support clear and consistent decision making and actions is a core enabler of system safety. This framework has standardised language for assessing the status of system pressures and the ASD continues to reflect and refine this to maximise a collegiate approach to proactively recognise and respond to emerging risks. OPEL is accessed by

the Senior Leadership Team regularly throughout the day, it is effectively informing operational, tactical and strategic engagement and decision making.

In their letter, HIS encouraged the use of safety huddles; one of the actions ASD SLT have agreed to test in December 2022 is an extension from the acute system daily patient safety huddle, as a visible and collegiate mechanism to initiate any actions stemming from the morning acute OPEL status.

Collegiate planning

The letter highlighted pressures on Emergency Departments, and acute admission areas as the weathervane of wider system pressure. These pressures were fully recognised and ASD SLT have a range of ongoing and capacity and flow improvement programmes in place drawing on the Unscheduled Care improvement programme. In addition to winter planning and in response to system pressures on 26th October 2022 the ASD held an improvement planning session to identify other actions to support capacity and flow. This generated a range of local improvement actions, which subsequent sessions have augmented, that ASD are collectively focused on progressing.

ASD SLT have supported wards and ED to review policies and procedures related to severe overcrowding, emergency fire evacuation and the storage and administration of medications to ensure that these and associated risk assessments are extant.

Reflecting on the themes of the letter ASD SLT note the following:

Overcrowding:

- A range of tests and improvement work are ongoing with HSCP colleagues to support care at or closer to home, including testing out enhancements to ‘call before to convey’ with the Scottish Ambulance Service.

- The new Rapid Triage Unit opened in November to maximise the space within ED and Admissions Unit 1 and improve the experience of people attending, the model and associated pathways continue to be measured, studied and refined to develop this Advanced Nurse Practitioner led model through an active learning approach to implementation.

- Direct pathways and pathways to minimise time within ED are being strengthened; this includes the creation of the 4 bedded trauma assessment bay within the Orthopaedic ward and refinement of assessment pathways.

- Rooms within ED have been repurposed to create treatment and diagnostic areas to ensure people are cared for within an appropriate setting. This has been undertaken with estates and facilities colleagues and does not include the inappropriate use of non-clinical areas to deliver clinical care.

- Risk assessment processes are in place should any patient need to be cared for in a non-standard area and the site safety huddle process ensures rapid acceleration to mitigate risks.

- ASD are actively engaging with other Board’s teams to draw on their learning of push models and have a clinically led group working to test and implement this in Fife.

- The NHS Fife estates team Fire Officers oversee fire strategy and evacuation planning which includes consideration of surge capacity and the evacuation of patients and staff. The Fire safety Policy GP/F2 is written to comply with the Fire (Scotland) Act 2005 and the national mandatory guidance's issued by NSS in CEL 11 (2011) Fire Safety Policy for Scotland.

- Where capacity pressures result in boarding and/or use of surge capacity; there is a daily virtual MDT huddle in place to maintain an active review of all patients being cared for in a ward we would not optimally allocate them to. In addition to the work ongoing to maximise discharge without delay with HSCP colleagues the VHK discharge lounge are developing a pull model tied in with the developing work with the Capacity Team to optimize supporting people in the right place at the right time.

- The ASD SLT has worked with estates and facilities colleagues to prioritise the work programme to optimise clinical space and ensure a focus on maintaining the clinical environment.

Supplementary staffing

- Recognising the workforce challenges, in addition to the Board's ongoing focus on recruitment and retention, safe to start conversations are a key feature of our daily safety huddles.

- Work is being progressed with the clinical teams to refine weekend handover arrangements to maximise oversight and awareness to support teams.

- ED are working to develop a sustainable medical workforce model

Staff wellbeing

- The ASD SLT are working to enhance further visible engagement with front line teams, including senior leader walk arounds and pop-up briefings and General Manager briefings

- The improvement activity referred to throughout this paper contains many ideas and initiatives that directly stem from front line staff feedback and suggestions, SLT are working to ensure that this is very visible

- The OPEL processes ensure consistent recording of decisions, actions and mitigation following escalation

- The Staff Well Being Hub on the VHK site opens next week, which will see this important staff rest area have a permanent home.

- Energy pods are being trialed in the ED staff well being area and within the theatre area from this week. This is to support staff rest as well as rejuvenation and well being.

Medicines Governance

The Director of Pharmacy and Medicines along with the Associate Director of Nursing have undertaken safety walkabouts in key clinical areas to identify and action issues in relation to the safe use and storage of medicines. Whilst there were areas of excellent practice noted in the resus and diagnostics areas, a number of improvement actions were identified:

- Improvement plan for both the minors and majors areas of the ED, with actions being closely monitored
- Review of processes for the prescribing and administration of medicines for those patients who experience extended waiting times in the ED
- Establishment of weekly medicines safety huddles to review medicines incidents and identify learning and improvement actions.
- Briefing sessions for nursing and pharmacy staff, on safe use and storage of medicines, with a focus on a collaborative approach to "See it, sort it" for any medicines issues identified
- The continued audit of medicine management processes to assure medicines governance

2.3.1 Quality / Patient Care

All aspects of the review and improvement actions noted above are focused on enabling and ensuring safe and effective, quality patient care

2.3.2 Workforce

All aspects of the above are also in support of enabling and maintaining the wellbeing of staff through clear effective and robust procedures and processes to ensure their and their patients' safety.

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

The overriding risks associated with capacity and winter pressures are logged in the Divisions risk register and associated corporate registers. The above summaries mitigation and management actions underway.

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

- The improvement ideas have been initiated through extended SLT sessions which included staff side representation
- Improvement ideas and actions have been shared at the Patient Safety Huddle

2.3.8 Route to the Meeting

- ASD Senior Leadership team have discussed the HIS letter and contributed to the development of this paper
- EDG 19th January 2023

2.4 Recommendation

The Clinical Governance Committee is asked to:

- **Assurance** – Note the ASD reflections in response to the HIS letter as well as the actions underway to support the ASD, patient care and staff wellbeing.

Report Contact
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Appendices:

Appendix 1: Summary of HIS Acute Inspections

Appendix 2: HIS Letter November 2022

HEI Inspection Reports Update: Safe Delivery of Care Inspection
Lessons Learned from other Boards 2022

DATE	HOSPITAL	GOOD PRACTICE	REQUIREMENTS	FLAG	PAGE
7-8 Dec 2021	Perth Royal Infirmary	5	2		2
18-19 Jan; 1 Feb 2022	University Hospital Monklands	4	7		3
22-24 Mar; 13 Apr 2022	Queen Elizabeth University Hospital	6	5		4
5-6 Apr; 19 Apr 2022	Forth Valley Royal Hospital	4	9		5
3-4 May; 29 Apr 2022	University Hospital Crosshouse	6	13		6
16-17 Aug; 6 Sep 2022	Western General Hospital	9	4		7

HOSPITAL	DATE	HEADLINES
NHS TAYSIDE **Perth Royal Infirmary** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with ward staff (where appropriate), and • accessed patients' health records, monitoring reports, policies and procedures.	7-8 Dec 2021	**BACKGROUND** Perth Royal Infirmary is a district general hospital with 267 inpatient beds. The hospital provides a variety of services for Tayside and North East Fife including accident and emergency, general surgery, general medicine and elderly medicine**.** Areas inspected were: • accident and emergency department • general outpatient department • medical assessment unit • orthopaedic outpatient department • ward 1 • ward 3 • ward 6 • ward 7 • public and staff communal areas of the hospital One area had 50% **supplementary staff** on the day shift and 36% supplementary staff on the night shift. There was a 12% **vacancy rate** within the Registered Nursing and 8% within the Healthcare Support Worker workforce for November 2021. In addition, we noted that collectively there was a **sickness absence** level of 5.85% within nursing and special leave absence of 5.69%, due to COVID-19 related absences.
		This inspection resulted in five areas of good practice and two requirements. **REQUIREMENTS:**
		1. NHS Tayside must ensure that, when a high level of supplementary staff is in place, the delivery of care continues to be organised and coordinated. This includes mealtimes and cleaning equipment following use
		2. NHS Tayside must ensure that all staff carry out hand hygiene at appropriate moments and use personal protective equipment in line with current guidance

HOSPITAL	DATE	HEADLINES
NHS LANARKSHIRE **University Hospital Monklands** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with ward staff (where appropriate) • spoke with 37 patients during our inspection • accessed patients' health records, monitoring reports, policies and procedures.	18-19 Jan 2022 1 Feb 2022	**BACKGROUND:** University Hospital Monklands is a district general hospital in Airdrie, North Lanarkshire, with a 24-hour accident and emergency department. Healthcare services include a renal unit, and medical and surgical inpatient services. It has 411 inpatient beds. Areas inspected were: • acute medical receiving unit; emergency department • ward 2; ward 4; ward 6; ward 7; ward 9; ward 10; ward 12; ward 14; ward 17; ward 18; ward 21; ward 22; ward 26 • public and staff communal areas of the hospital. Inspectors returned to University Hospital Monklands on Tuesday 1 February 2022 to follow up on an area of concern identified during the earlier inspection. Some areas within the hospital were working with a high number of **supplementary staff.** December 2021 workforce data showed there was a **17% vacancy rate** across the Registered Nursing workforce and an **8% vacancy rate** within the Healthcare Support Worker workforce. In addition, we noted high levels of **sickness absence, 10.8%** within nursing, with special leave absence rates of **3.4%,** related to COVID-19.
		This inspection resulted in four areas of good practice and seven requirements. **REQUIREMENTS:**
		1. A robust process will be established across NHS Lanarkshire to ensure safe patient placement when utilising non-standard clinical areas for patient care
		2. NHS Lanarkshire will continue to work to ensure risk assessments and care plans are regularly evaluated and updated to reflect changes in the patient's condition or needs, and that all relevant documentation is in place and completed
		3. NHS Lanarkshire will ensure that patient mealtimes are managed consistently and that patients receive adequate support at mealtimes
		4. NHS Lanarkshire will ensure that all staff carry out hand hygiene at appropriate moments and use personal protective equipment in line with current guidance
		5. NHS Lanarkshire will ensure that there are systems in place to assure themselves that essential maintenance works are completed to the correct standard and any risks to patients and staff are identified and managed
		6. NHS Lanarkshire will ensure a balanced approach when distributing supplementary staffing, ensuring consideration is given to levels of patient dependency and complexity when making real time staffing decisions
		7. NHS Lanarkshire will ensure that systems and processes are in place to identify, assess, manage and communicate any patient safety risks throughout the organisation.

HOSPITAL	DATE	HEADLINES
NHS GG&C **Queen Elizabeth University Hospital** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with ward staff (where appropriate) • accessed patients' health records, monitoring reports, policies and procedures.	22-24 Mar 2022 13 April 2022	**BACKGROUND:** The Queen Elizabeth University Hospital, Glasgow, opened in April 2015. The campus has 1,860 beds with a full range of healthcare specialities, including a major emergency department. In addition to the 14-floor hospital building, the hospital campus retains a number of other services in adjacent facilities. This includes maternity services, the Royal Hospital for Children, the Institute of Neurological Sciences, and the Langlands Building for medicine of the elderly and rehabilitation. Areas inspected were: • acute receiving medicine for the elderly (ARU 4); emergency department; immediate assessment unit • high dependency unit (critical care unit 1); specialist assessment and treatment area (SATA) • ward 5A, 5B, 5C, 5D, ward 6C, 8A, 8D, 9A, 9D, 10B, ward 66, 67, 11, ward 5, 12 • In the maternity unit: ward 49; 13 • In the Royal Hospital for Children: emergency department, ward 3C. Reported that: • high staff absence due to sickness and requirements to self-isolate • long patient waiting times in the emergency department • a high hospital occupancy rate with just over 5% available 'empty beds'. There were 33 wards across the hospital campus, scoring a nurse staffing risk rating of red at the start of the day. This means that nursing staff numbers or skill mix may be creating a risk to patient safety, or there are issues affecting patient safety that requires immediate attention. The evening before our inspection, the emergency department had put 'a divert' in place for 1 hour.
		This inspection resulted in six areas of good practice and five requirements. **REQUIREMENTS:**
		1. NHS Greater Glasgow and Clyde must ensure the environment in SATA continues to be suitable for the provision of care in a respiratory pathway. This includes: a) Sufficient hand hygiene facilities b) Appropriate storage and access to PPE c) Adequate placement of patients
		2. NHS Greater Glasgow and Clyde must ensure patient mealtimes are managed consistently and that patients receive adequate support at mealtimes.
		3. NHS Greater Glasgow and Clyde must ensure that patient equipment is cleaned effectively.
		4. NHS Greater Glasgow and Clyde must ensure that all staff carry our hand hygiene at appropriate moments and the correct use of PPE in line with current guidance.
		5. NHS Greater Glasgow and Clyde must ensure wash hand basins are dedicated and used only for hand hygiene.

HOSPITAL	DATE	HEADLINES

NHS FORTH VALLEY **Forth Valley Royal Hospital** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with patients, visitors and ward staff (where appropriate) • accessed patients' health records, monitoring reports, policies and procedures.	5-6 Apr 2022 19 April 2022	**BACKGROUND:** Forth Valley Royal Hospital, Larbert, is an 860-bedded hospital. It became fully operational after the transfer of acute services from Stirling Royal Infirmary in July 2011. The hospital provides a wide range of inpatient, outpatient and day services such as day surgery, emergency care, women and children's services and critical care. Areas inspected were: • acute assessment unit; emergency department; intensive care unit; wards A12; A31; A32; B21; B23; B31 • public and staff communal areas of the hospital. Inspectors returned to Forth Valley Royal Hospital on Tuesday 19 April 2022 to follow up on areas of concern identified during the earlier inspection and visited three additional wards A11, B11 and B32. **Vacancies** across the teams were high within all staff groups; registered nursing staff group which was **10.5%** and the medical staff group which was **13.76%.**
		This inspection resulted in six areas of good practice and nine requirements. **REQUIREMENTS:**
		1. NHS Forth Valley must ensure that care and comfort rounding charts are completed within the prescribed timeframes
		2. NHS Forth Valley must ensure hospital ward doors are only locked in accordance with the locked door policy; All staff who apply the locked door policy are fully aware of the correct process
		3. NHS Forth Valley must ensure that all sterile stock is stored appropriately to reduce the risk of cross infection, in line with the National Infection Prevention and Control Manual
		4. NHS Forth Valley must ensure that all staff comply with hand hygiene and the use of gloves, in line with the National Infection Prevention and Control manual
		5. NHS Forth Valley must ensure that cleaning is in line with national guidelines and local policy, particularly in relation to additional beds.
		6. NHS Forth Valley must ensure there are effective risk management systems and processes in place to ensure the safe delivery of care where additional beds or nonstandard care areas are in use; must ensure all the issues raised through our escalation process are addressed and the improvements made are maintained
		7. NHS Forth Valley must ensure that senior management decision making regarding staffing risks and mitigations are open and transparent
		8. NHS Forth Valley must ensure it has a clear understanding of the number of actual staff in post and that workforce data is accurately presented
		9. NHS Forth Valley must ensure that systems and processes are in place to identify, assess, manage, and effectively communicate any patient safety risks throughout the organisation

HOSPITAL	DATE	HEADLINES

NHS AYRSHIRE & ARRAN **University Hospital Crosshouse** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with patients, visitors and ward staff (where appropriate) • accessed patients' health records, monitoring reports, policies and procedures.	3-4 May 2022 29 April 2022	**BACKGROUND:** University Hospital Crosshouse serves the north and east Ayrshire areas. It has a full range of healthcare specialties. It has 575 beds.The hospital provides maternity services for the whole of NHS Ayrshire & Arran at the purpose-built Ayrshire Maternity Unit. Areas inspected were: • ward 2A, 2B, 3B, 4A, 5B, 5D, Ayrshire maternity unit, emergency department, acute cardiac care unit, combined assessment unit, public and staff communal areas of the hospital
		This inspection resulted in six areas of good practice and thirteen requirements. **REQUIREMENTS:**
		1. NHS Ayrshire & Arran must ensure that systems and pathways used to direct patients to services are up to date with accurate information documenting where and how care is best provided.
		2. NHS Ayrshire & Arran must ensure that people in hospital are treated with privacy and dignity, and that all patients have suitable access to facilities to meet their hygiene needs.
		3. NHS Ayrshire & Arran must ensure there are effective risk management systems and processes in place to ensure the safe delivery of care including where additional beds or nonstandard care areas are in use.
		4. NHS Ayrshire & Arran must ensure that staff are trained and knowledgeable in fire safety and are able to provide care and support in a planned and safe way when there is an emergency or unexpected event.
		5. NHS Ayrshire & Arran must ensure that care and comfort rounding charts are consistently completed and within the timeframes with actions recorded.
		6. NHS Ayrshire & Arran must ensure that all staff remove single use personal protective equipment immediately after each patient care activity and/or the completion of a procedure or task in line with the NIPCM
		7. NHS Ayrshire & Arran must ensure that all staff carry out hand hygiene at appropriate moments and use personal protective equipment in line with current guidance.
		8. NHS Ayrshire & Arran must ensure the environment is maintained to allow effective decontamination
		9. NHS Ayrshire & Arran must ensure they have systems in place to assure themselves that essential maintenance works are completed to the correct standard and any risks to patients and staff are identified and managed.
		10. NHS Ayrshire & Arran must ensure care and support is provided in a planned and safe way and the care provided is responsive to patients' needs.
		11. NHS Ayrshire & Arran must review their systems and processes to ensure a consistent approach to clearly recording staffing decisions, escalations and mitigations.
		12. NHS Ayrshire & Arran must ensure that systems and processes are in place to identify, assess, manage and effectively communicate any patient safety risks throughout the organisation.
		13. NHS Ayrshire & Arran must ensure that patients are provided with the right care, in the right place, at the right time.

HOSPITAL	DATE	HEADLINES
NHS LOTHIAN **Western General Hospital** • inspected the ward and hospital environment • observed staff practice and interactions with patients, such as during patient mealtimes • spoke with patients, visitors and ward staff (where appropriate) • accessed patients' health records, monitoring reports, policies and procedures.	16-17 Aug 2022 6 Sep 2022	**BACKGROUND:** The Western General Hospital, Edinburgh, serves the Lothian region. It contains approximately 570 staffed beds and has a full range of healthcare specialties. This includes the regional centre for cancer treatment for the south-east of Scotland and the department of clinical neurosciences, which provides specialist services to patients across much of Scotland Areas inspected were: • Intensive care unit, medical assessment unit, minor injuries unit, same day emergency care (SDEC) • wards 15, 24, 51, 54, 70, 73 • public and staff communal areas of the hospital. Inspectors returned to WGH on 6 September 2022 to follow up on areas of concern identified in SDEC during the earlier inspection
		This inspection resulted in nine areas of good practice, one recommendation and four requirements. **REQUIREMENTS:**
		1. NHS Lothian must ensure that care and comfort rounding charts are consistently completed, and within the timeframes.
		2. NHS Lothian must ensure that there are systems and processes in place to support clinical staff when there is an absence of the expected senior leadership and management roles within the team.
		3. NHS Lothian must ensure they have systems in place to assure themselves that essential maintenance works are completed to the correct standard and any risks to patients and staff are identified and managed.
		4. NHS Lothian must ensure all infrequently used water outlets are flushed in line with guidance.

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NHS Chief Executives

Executive Nurse Directors

Medical Directors

Pharmacy Directors

11 November 2022

Dear Colleagues

Safe Delivery of Care inspections of acute hospitals

You will recall I wrote to you on 20 April this year to alert you to some serious concerns that had come to light during our initial Safe Delivery of Care acute hospital inspections in order that you could review systems and procedures within your Boards.

We have now carried out seven Safe Delivery of Care acute hospital inspections. The inspections undertaken so far continue to identify good examples of staff working together, in difficult circumstances, to manage and mitigate risks during a time of unprecedented system pressures. Despite the challenges associated with patient flow, waiting times and workforce pressures our inspections have highlighted many positive and caring interactions between staff and patients, with staff working extremely hard to deliver safe care. We have also observed examples of good practice in the use of safety huddles to manage patient care and patient flow.

However, we have identified further serious concerns that we wanted to alert you to so you can review the systems and procedures within your Boards. These are concerns which directly impinge on the safety of patients and staff.

Of the seven inspections undertaken so far, we have found instances of extreme overcrowding in emergency departments and other admission units. Inspections have revealed patients seated in corridors and chaired waiting areas for extended periods with care needs such as fluid and nutrition and administration of medicines not being met, and many patients being cared for in non-standard care areas, such as treatment rooms or areas with increased bay capacity. Whilst we understand the unprecedented pressures on services, our inspectors have frequently found a lack of application of risk based approaches in assessing and caring for patients being placed in these areas, which has impacted the Board's ability to mitigate the associated risks and ensure safe patient placement, care and dignity. We have also identified concerns in relation to patient and staff safety in the planning for and staff awareness of emergency fire evacuation procedures within these overcrowded areas.

We continue to observe the impact of higher than normal levels of supplementary staffing on patient care, and have witnessed an understandable focus on patient flow in planning and

decision making. However, when making decisions about the deployment of resources we would urge all Boards to take individual patient acuity, dependency and complexity into consideration during safety 'huddles' and when making real time staffing decisions in the distribution and deployment of staff.

In addition staff well-being continues to be a prominent feature of our inspections, with staff expressing feelings of exhaustion and highlighting to inspectors concerns around their ability to provide safe patient care, escalate concerns and feel that they are being listened too.

We have also identified instances of unsafe practice around medicines governance which could result in serious harm to patients. For example, inspectors have observed prepared intravenous medications left unattended in open ward areas, inadequate checks of medication, dose or patient details and medication cupboards left unlocked and unattended.

We would encourage all Boards to ensure that senior managers are proactive in identifying risks to patient safety, rights and wellbeing, including but not limited to those described within this letter, to enable appropriate action to be taken to promptly mitigate any associated risks.

We would ask all Boards to review their policies and procedures in relation to areas of severe overcrowding, emergency fire evacuation and storage and administration of medications to ensure that risk assessments, policies and procedures are being reviewed, updated and appropriately applied. We would also ask that you assure yourselves that all staff, including supplementary staff and managers are familiar with these policies and procedures.

We welcome your consideration of the important issues outlined above and appreciate your ongoing contribution to our inspections at this challenging time for NHS Scotland. We have worked closely with Directors of Nursing to highlight and share our inspection findings to date and support learning. Our current winter webinar series is focused on topics such as 'safe to start' and 'a system under pressure' providing a range of techniques and approaches to support, promote and share practice across Boards during this time of unprecedented pressure. We will continue to share the learning from our inspections over the coming months and offer ongoing improvement support to the system.

I am sure you will wish to bring this letter to the attention of other appropriate colleagues in your respective systems, including Chief Officers of Integration Joint Boards. I have also copied this letter to the Chief Operating Officer, National Clinical Director, Chief Medical Officer and Chief Nursing Officer at the Scottish Government for their awareness and consideration.

We look forward to continuing to work with you to support the delivery of safe, effective, person-centred care.

Yours Sincerely

Lynsey Cleland
Director of Quality Assurance

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Resilience Assurance Update**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Susan Cameron, Head of Resilience**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Assurance
- Decision

This report relates to:

- Annual Delivery Plan
- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

This report provides an assurance update for NHS Fife about its:

- Preparedness for civil emergencies & legal duties as a Category 1 responder within Civil Contingencies Act 2004
- Manager preparedness for any event requiring business continuity (BC).
- Provision of information, instruction & training support for its employees in relation to civil contingencies planning & preparedness.

NHS Fife (as a public service organisation) being able to evidence resilience assurance to its statutory & moral obligations

It is proposed that the Clinical Governance Committee receive an Annual statement of Assurance for Resilience using the template established by other sub-groups of Committee.

2.2 Background

As a Category 1 responder, NHS Fife is required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency planning
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency

Emergency Planning

Working Major Incident Plan (2019)

A draft Major Incident Plan has been available as a working document in NHS Fife since 2019. In August 2022 the Respond section of Major Incident emergency planning was tested at the VHK Emergency Department with a live play Hazardous Materials (HAZMAT) scenario involving multiple casualty decontamination. This was supported by volunteers from the British Red Cross.

Learning following this event has been taken forward with Chemical, Biological, Radiation & Nuclear (CBRN) kit and local guidance. The Radiation Protection Advisor provided post event training on radiation decontamination response, equipment & exposure hazards. Scottish Government CBRN lead provided training in October 2022 on Powered Respirator Protective Suits (PRPS), train the trainer.

NHS Fife has also committed to train 10 non-clinical HAZMAT responders able to the Emergency Department or other clinical areas in any HAZMAT/CBRN response situation.

Refreshed Major Incident Framework

NHS Fife's Major Incident Framework is expected to be ratified by June 2023 and will then supersede the 2019 Working Major Incident Plan. The framework will have 3 sections, in line with Prepare Scotland national guidance, and with the emergency management cycle:

- **Prepare** – establishing the structure of our Acute Services, and the roles and responsibilities of partner agencies, ahead of any Major Incident
- **Respond** – protecting lives and assets such as our hospital infrastructure, including management communication links, the patient journey, and key actions during a Major Incident.
- **Recover** – the coordinated process of recovery for affected areas and the organisation after a Major Incident

Business Continuity Management Arrangements

The current Business Continuity Assurance statement and overarching Corporate Business Continuity Plan were presented to EDG in December 2020. The Assurance statement for 2021/22 was delayed because of a combination of operational pressures and key vacancies within the resilience team.

The Assurance of Resilience Capabilities procedures ensures all directorates and operational areas of NHS Fife routinely report on their ability to prevent disruption to

services, manage disruptive incidents, and respond to internal & external emergencies, including major incidents.

Internal Audit carried out a review of Resilience arrangements as part of their routine Internal Audit Plan. reporting cycle in 2021/22. An Interim Internal audit has been completed and highlighted some issues affecting resilience, noting that limited assurance was possible due to vacancies and additional workload during the COVID-19 pandemic. A further full system review is part of the 2022/23 Internal Audit Plan.

The Resilience Forum provides oversight of the resilience function across NHS Fife; it is chaired by the Director of Public Health and its membership is drawn from key NHS Fife stakeholders. Within each directorate and operational area of NHS Fife, the Executive Director / General Managers are required to provide a formal assurance report to the Resilience Forum by the 31 October each year. This year due to ongoing operational pressures the deadline for declaration was extended to the 31 December 2022, assurance returns will be collated in Quarter 4.

NHS Fife intranet pages about Emergency Preparedness & Resilience & response were published in March 2022 to raise awareness and support all operational areas with development of their plans. There is ongoing work to establish baseline availability of local business continuity plans and offer training and support.

PREVENT

In Quarter 2 (2022) the Resilience team took responsibility for the **PREVENT** portfolio across NHS Fife. Advice is available from NHS Fife's Resilience team & information to raising concerns is now accessible via the EPRR Staff link pages, and concerns can be raised in confidence via **fife.resilience@nhs.scot**

PREVENT leads work with local partners to protect vulnerable people at risk of being groomed or exploited by extremists.

PREVENT Training on TURAS

2022/23 Quarter	H&SCP Staff Trained	Acute Staff Trained
1	131	234
2	131	138
3	172	159

2.3 Assessment

Despite ongoing pressures, work is progressing well to engage and support service areas with updating their plans and assure NHS Fife's resilience preparedness.

Emergency Planning

Four framework guidance documents sit alongside the Major Incident Framework plan;

- Severe Weather Framework Plan
- Suspicious Package & Bomb Threat Framework Plan
- Lockdown Framework Plan
- Scientific & Technical Advice Cell (STAC) with East of Scotland Regional Resilience Partnership stakeholders

Stakeholder engagement, consultation and an editorial checklist will support final document ratification.
All Major Incident framework documents are held in a central document ledger and will be reviewed at least every two years in line with national guidance.

The Framework plans will be tested by means of tabletop and live play scenario exercises to support learning and ensure that the plans work as intended, This process of testing is an integral part of resilience and will ensure NHS Fife can deliver and co-ordinate an effective emergency response.

Business Continuity Planning
In March 2022 resilience and business continuity planning was reviewed across Acute Services & Fife H&SCP.

NHS Fife and Fife H&SCP have jointly identified 129 areas requiring business continuity planning including impact assessments and response plans for the area. Where we have received partial assurance that business continuity plans are in progress the Resilience team are providing tools, training, and support. A central repository of all plans is being enabled to ensure availability in any Major Incident.

Division	**BC Plan confirmed as up to date**	**BC Plan advised to be in progress**	**BC Plan update not provided by service area**	**Total**
Acute & Corporate Services	39	34	1	74
H&SCP	50	1	4	55

Two workshops have taken place with Executive Directors focusing on business continuity and resilience planning. The output from these workshops will be used to refine a strategic decision-making framework for management of internal and external incidents.

Business Continuity Training
The Resilience team have established regular BC training update sessions. 33 training sessions have been provided to 162 staff.

Digital resilience partners provide monthly digital resilience presentations.

Business Continuity Plan (BCP) Testing & Exercising
NHS Fife's Business Continuity Plans (BCPs) include arrangements for testing and exercising for ensuring arrangements for the provision of training to those involved in implementing the plan. Annual testing and exercising ensures BCPs are kept up to date and continue to be appropriate. Integral to that is the practising and testing of all the elements of emergency plans. Training staff to be involved in emergency planning and response is fundamental to our organisation's ability to be prepared for any type of emergency. Testing exercises have 3 main purposes:

- to validate plans (validation)

- to develop staff competencies and give them practice in carrying out their roles in the plans (training)
- to test well-established procedures (testing)

BCPs cannot be considered reliable until they have been exercised and proven to be workable. All participants in exercises should have an awareness of their roles and be reasonably comfortable with them before they are subject to the stresses of an exercise. Exercising tests procedures and plans, not people.

An important aim of any exercise is to make people feel more comfortable in their roles and to build morale. If staff are under-prepared and an incident does occur, recovery and impact to services can be prolonged.

Annual BCP testing and exercising will commence in March 2023. This will assist NHS Fife to build on the BCP contingencies awareness and will enhance planning quality.

2.3.1 Quality / Patient Care

Major Incident Frameworks will increase situational awareness and strengthen the ability of the organisation to protect patients and workforce from any unforeseen events.

2.3.2 Workforce

Senior Leadership Team within Acute Services have agreed a rolling programme of business continuity testing & exercising to commence in March 2023.

2.3.3 Financial

Testing and Exercising planned will provide mitigating incident support and promote a quicker & more effective and less costly recovery response to unforeseen adverse events.

The main costs arising from exercising will be in time required by staff to take part. There may be an additional need for NHS fife to support the resilience team with equipment & educational resources to support civil contingencies planning.

Major Incident Emergencies and business continuity incidents have the potential to rapidly cause financial impact. Investment in planning for preparedness reduces overall Major Incident recovery costs.

2.3.4 Risk Assessment / Management

Risk mitigation actions include;

- Annual work planning with key stakeholders for resilience planning, information, instruction and education.

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

Equality and Human Rights lead invited as a member of the NHS Resilience Forum.

2.3.6 Climate Emergency & Sustainability Impact

Nil

2.3.7 Communication, involvement, engagement and consultation

A quarterly Resilience workforce briefing newsletter is being developed for management and workforce teams to support awareness of frameworks and situations.

Quarter 1, 2 & 3 Resilience reports for assurance have been considered by the NHS Fife Resilience Forum, and then presented to Executive Director Group (EDG).

Meetings:

NHS Resilience Forum (RF) meetings	Executive Director Group (EDG) meetings
23 February 2022	Quarter 1 - 16 June 2022
18 May 2022	Quarter 2 - 17 November 2022
15 June 2022	Quarter 3 - 19 January 2023
25 August 2022	
1 December 2022	

Workforce Engagement

A short COVID-19 business continuity survey was undertaken in July 2022 where feedback received indicated a lot of NHS managers are looking for support. When asked specifically to type of support needed, 43% of management responses mentioned BC Plans.

75% of managers said that business continuity plans were useful during the pandemic, and 49% said they would value additional support from the Business Continuity team.

2.3.8 Route to the Meeting

This paper has been prepared to provide an interim progress update to CGC in advance of an annual board assurance paper for 2023.

2.4 Recommendation

This paper provides an overview of work to update and refresh business continuity and emergency planning across the organisation. The normal cycle of assurance has been disrupted due to a combination of pressures. It is proposed that the Clinical Governance Committee will receive an Annual statement of Assurance for the year in line with that provided by other sub-groups. This will be presented at the May meeting.

- **Assurance** – Overview of progress within business continuity and emergency planning is provided for Members' information and assurance.
- **Decision**- Seeking agreement that formal Annual Statement of Assurance is presented in May annually to Clinical Governance Committee. This will align with completion of business continuity assurance process.

3 List of appendices

The following appendices are included with this report:

- No Appendices

Report Contact

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Committee Self-Assessment Report 2022/23**
Responsible Executives:	**Dr Chris McKenna, Medical Director / Janette Keenan, Director of Nursing**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Clinical Governance Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

2.2 Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

A light-touch review of the standard question set was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the questionnaire. Board Committee Chairs each approved the set of questions for their respective committee.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in early February 2023. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite responses for the Clinical Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference and no significant matters of concern were raised. It was noted that agenda setting meetings give the opportunity to allow for consideration of topical matters not on the standard workplan, and that pre-Committee meetings with the Non-Executive membership give an opportunity to discuss the appropriateness of the meeting agenda, queries to be addressed and its focus on matters of significance.

Self-Assessment questionnaire (completed by members and attendees)

In total, ten members (excluding the Chair) and six regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a relatively positive assessment from its members and attendees who participated. The addition of Development Sessions to allow for greater briefing / training opportunities has been welcomed, though it is noted that these could allow for more information to be made available on emerging national strategies and initiatives (Value-based healthcare being cited as an example). Changes to the Corporate Risk Register presentation was also broadly welcomed, with initial improvements seen in this area over the past few months of reporting. The need to maintain a focus on strategic, rather than operational, detail was a common theme, which is an important factor in ensuring the correct governance focus of the Clinical Governance Committee versus its sub-structure of reporting groups.

Some specific areas for improvement were highlighted. Initial comments identified for further discussion include:

- further work required on making agendas and meeting packs manageable in the time allowed for meetings (it had been anticipated that the set-up of the Public Health & Wellbeing Committee should have helped spread more of the load of required business, but perhaps this still needs refinement?);
- related to the above, the distribution of late papers for meetings should be minimised where at all possible;
- for performance reporting, ensuring that data is provided with clear and unambiguous analysis from the Executive on whether progress is positive or negative (and what level of assurance can be taken therefrom);
- a number of comments indicating that a Development Session on key Clinical Governance principles and members' roles and responsibilities (including discussion on whether the current membership is sufficient) is likely to be beneficial; and
- a recognition that newer Non-Executive members need time to gain appropriate knowledge and skills in what is a complex area for those of a non-clinical background.

In relation to the issue of induction and allowing new members to develop appropriate knowledge of the key areas under the Committee's remit, it is suggested that in 2023/24 a specific Induction Handbook is created for each Board Committee, containing key information such as Terms of Reference, Membership, the previous year's Annual Committee Assurance Report and any further reading / links to national strategies or guidance of particular relevance to each Committee's area of responsibility. This document can be refreshed regularly, as required, and would be expected to take the form of pre-reading material for new members before they meet with the Committee Chair and Executive Lead as part of their formal introduction to their new committee.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Directors.

2.4 Recommendation

This paper is provided for:

- **Discussion** – what actions members would wish to see implemented to address those areas identified for improvement.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Outcome of Committee's self-assessment exercise

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

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics						
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	4 (25%)	12 (75%)	-	-	-
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	8 (50%)	7 (44%)	1 (6%)	-	It might be good to consider more clinician membership.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	3 (19%)	12 (75%)	1 (6%)	-	Clarity of purpose of committee can be confused at time, and is evident through discussions e.g. on operational detail. This is further conflated at time by the composition of membership. Purpose should be to supervise and assure clinical governance, however there is a potential conflict of interest with some members being asked to assure the committee. In addition, the role of staff side attendee can be unclear and conflated as not a Board member. Do sense the newly appointed Non-Executives are on their way to this point - still early for them. Work to be done with the Non-Executive members.
A4.	Committee members are able to express their opinions openly and constructively.	5 (31%)	11 (69%)	-	-	Agendas are very busy. Papers are presented by the same people, would be good to hear from the Deputy Medical Directors and Assistant Director of Nursing.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	2 (13%)	13 (82%)	1 (6%)	-	Sometimes, due to the lengthy agenda, effective scrutiny can be difficult. This is especially the case when critical or sensitive matters need time to be talked through. See above comments re membership creating potential conflict of interest. Challenge at times can be either too operational or at times do not conclude scrutiny with levels of assurance taken from evidence. For example, when issues regarding clinical governance performance are discussed, the Committee does not affirm the levels of assurance they have regarding the level of performance, whether to improve or tolerate the performance. There is within the remit of the Committee. Some of the scrutiny comes in areas that are potentially outwith the Committee's specific remit, but still legitimate challenge. I suspect this results in the Committee members being reluctant to always challenge. Is the requirement for demarcation having other consequences? Volume of papers can make it difficult to digest and scrutinise fully. Sometimes there is too much focus on operational detail.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	-	14 (88%)	2 (13%)	-	The Committee is always open to training for members but once again time can be an issue. In the past two meetings there has been challenge from the Executive on the remit of the Committee. Development session really helpful with this. This is hard to assess and may be beneficial to ask those who more recently joined the CGC about their requirements separately.
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	1 (6%)	14 (88%)	1 (6%)	-	A good mix of diverse backgrounds helps with scrutiny. Members actively seeking to understand areas they do not have a full grasp of. This is the area I am most concerned about - I don't feel that the questioning has been as appropriate with the attrition of the experienced Non-Execs.
B. Committee meetings, support and information						

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
B1.	The Committee receives timely information on performance concerns as appropriate.	5 (31%)	10 (63%)	1 (6%)	-	There is a lag in reporting dates up to 3 months in some instances. This is difficult from an assurance perspective when we think about risks and effectiveness of mitigating factors. Information received - no overt assurance it is understood by all that I'm aware off. The refreshed IPQR brings performance concerns to light well and there is good discussion on these elements. However, the data is usually retrospective by several months.
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	4 (25%)	12 (75%)	-	-	I have seen one example of this.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	3 (19%)	12 (75%)	1 (6%)	-	This is perhaps an area that could be strengthened. There are some additional reports that the Committee might wish to consider e.g. Chief Medical Officer report on Values Based Health and Care. A number of clinical strategies which have been published have yet to be discussed. Some items which should be discussed, for example Values Based medicines should be considered for the agenda and transitioned into NHS Fife policy and strategy. On reflection - I wonder if this is clear for committee. NHS Fife appears to me in areas to be ahead of the requirement of NHS Scotland's policy directions/instructions and in some cases may be hindered by NHS Scotland's directives.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	2 (13%)	12 (75%)	1 (6%)	1 (6%)	This is always a difficult balance, sometimes I feel there is too much information when others are looking for more. Some reports could be condensed or more focussed SBAR outlining key points for those non-clinical attendees. I do think it is balanced for the CGC. There still seems to be a desire for more detail - but perhaps this is reflective of new members finding their feet and understanding where the issues are being managed throughout the organisation. Volume is too great sometimes to allow full consideration of issues. Volume of papers is an issue. The volume of papers for each meeting is excessive.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	4 (25%)	11 (69%)	1 (6%)	-	This has not always been possible due to the exceptional demands. The agenda remains very lengthy, and it is not always feasible to effectively scrutinise the minutes of the supporting groups and sub committees. For the volume of papers there is insufficient time to adequately scrutinise.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	1 (6%)	12 (75%)	3 (19%)	-	Agree, although see previous comment re lengthy agenda. Occasionally lengthy agenda reduces discussion time. Meeting agenda can often be long; however, the commitment is clear from committee members to discuss for as long as needed. Agenda can often be so long that time can be pushed on certain items, perhaps more an agenda setting point? The meetings appear to be run to the time available, rather than round the areas needing discussion. Timings on the agenda may assist? Committee allows greater time where possible to discuss substantive matters, but the volume of material remains challenging. Time management is an issue - sometimes the loss of focus leads to time wasted discussion on superfluous issues.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						As before - lots of papers can dilute discussion. Not for the volume of papers.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	10 (63%)	6 (38%)	-	-	Good to see improvement work in this area in terms of standardisation of minutes.
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	8 (50%)	8 (50%)	-	-	-
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's strategies, policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	2 (13%)	12 (75%)	2 (13%)	-	Within the comments/observations made above.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub groups) is operating effectively as part of the overall governance framework.	2 (13%)	13 (82%)	1 (6%)	-	Not to do with the effectiveness of the group, however significant number of groups report into this committee and as such clarity and reporting could be improved through work plans and implementation of the clinical governance framework.
C. The Role and Work of the Committee						
C1.	The Committee reports regularly to the Board verbally and through minutes, can escalate matters of significance directly and makes clear recommendations on areas under its remit when necessary.	7 (44%)	9 (56%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	1 (6%)	13 (81%)	2 (13%)	-	Although on occasion, there can be a tendency to reach into operational detail which is not appropriate in the context of the governance role. As above, not to do with the effectiveness of the group, however significant number of groups report into this committee and as such clarity and reporting could be improved through work plans and implementation of the clinical governance framework. Although given the complexity of issues considered there can be occasions when questioning goes to an operational level of detail. I am concerned that there may be a desire to move the committee into a more granular space.
C3.	The Committee's agenda is well managed and ensures that all topics with the Committee's overall Terms of Reference are appropriately covered	4 (25%)	12 (75%)	-	-	At times there remains a duplication between Clinical Governance Committee and Public Health & Wellbeing Committee. Length of agenda can be problematic. The agenda does - the time available for the remit may be a limiter?
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	3 (19%)	13 (81%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	I think increased Non-Executive representation would be beneficial. On occasion there have been a lot of detail-intensive papers for one meeting - it can be difficult to ensure that all of them have been given equal attention and scrutiny, especially when there is only a short time to read them before the meeting. We could improve the information given for assurance of effective risk management. Specifically, we need to consider how the Committee is assured of not just the existence of governance channels but on the level of effective flow of information across these and oversight of effective management of risks to clinical quality. Where there is overlap with other committees this could be better managed. Reduced agenda? To allow more focussed time where appropriate. Consider limiting page-length for SBARs presented. Reduce the volume of papers per meeting.				
D. Clinical Governance Committee specific questions						

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
D1.	The Committee is provided with appropriate assurance that the corporate risks related to the specific governance areas under its remit are being managed to a tolerable level.	2 (13%)	11 (69%)	3 (19%)	-	Significant work has been undertaken in this area recently, which has brought greater clarity around risk tolerance/management. This is difficult in the current climate. There has been excellent work to improve risk management. I believe more needs to be done to show impact of improvement plans, controls and mitigation in line with Assurance Principles. Board risk appetite agreed last July and new corporate risk register only recently launched and being embedded. As such further work to ensure link between above and risk appetite in the organisation. Tolerance should be considered in this context. This links to comments regarding levels of assurance. Complex factors appear at this time around system pressures. Further work required to join up work on tolerance, alongside position of the system. We are at an early stage with considering corporate risks in the new process, but these have been very positively received. New risk framework and deep dives supports this well.
D2.	The performance information and data presented to the Committee allows for easy identification of deviations from acceptable performance (both negative and positive).	3 (19%)	10 (63%)	3 (19%)	-	Again, significant work has been undertaken in this area, which has been positive We can see deviation. This is difficult in current context with system position. Challenging to scrutinize and manage appropriately. Important to consider what this means in NHS Scotland in 2023. Lots of use of technical language and large volume of papers.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
D3.	Where there is a negative deviation from acceptable performance, the Committee receives adequate information to provide assurance that appropriate action is being taken to address the issues.	2 (13%)	13 (82%)	1 (6%)	-	What is not as clear is what is being done, the impact of this and the connection of performance with quality and safety. Where possible. As above, this is difficult in current context with system position. Challenging to scrutinize and manage appropriately. Important to consider what this means in NHS Scotland in 2023. The assurance is provided but receives limited comment from the Committee - time constraints?

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Annual Review of Committee's Terms of Reference**
Responsible Executives:	**Dr Chris McKenna, Medical Director; Janette Keenan, Director of Nursing**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Decision

This report relates to:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board thereafter.

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2022, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. Proposed amendments are either general updates to reflect reporting lines and current names of groups / processes, with some specific changes noted below:

- updating the references to the risk management reporting arrangements, given the replacement of the Board Assurance Framework by the Corporate Risk Register;

- expanding on the Committee's role in relation to adverse events and duty of candour assurance; and
- inserting a specific clause in relation to the Committee's role in oversight of patient feedback mechanisms.

An update on the proposed means of ensuring that the patient voice is heard on the Committee will be given at the meeting.

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

The regular review and update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided to the Board.

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for

- **Decision** – consider the attached remit, advise of any proposed changes and approve a final version for further consideration by the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Clinical Governance Committee's Terms of Reference

Report Contact
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Head of Corporate Governance & Board Secretary
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CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

1.2 To observe and check the clinical governance activity being delivered within NHS Fife and provide assurance to the Board that the mechanisms, activity and planning are acceptable.

1.3 To oversee the clinical governance and risk management activities in relation to the delivery of the existing Clinical Strategy.

1.4 To evaluate agreed actions relevant to clinical governance in the implementation of the developing Population Health & Wellbeing Strategy, including assessing the quality and safety aspects of new and innovative ways of working.

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

1.6 To oversee patient experience and feedback mechanisms and associated activity and seek assurance that learning and ongoing improvements are responsive to complaints feedback and in line with national standards and Ombudsman guidance.

~~1.6~~1.7 To assure the Board that the Clinical and Care Governance Arrangements in the Integration Joint Board are working effectively.

~~1.7~~1.8 To escalate any issues to the NHS Fife Board, if serious concerns are identified about the quality and safety of care in the services across NHS Fife, including the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum

- One Representative from Area Clinical Forum
- ~~One Patient Representative~~

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Acute Services
- Director of Finance & Strategy
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Associate Director, Digital & Information
- Associate Medical Director, Acute Services Division
- Associate Medical Director, Fife Health & Social Care Partnership
- Associate Medical Director, Women & Children's Services
- Associate Director of Quality & Clinical Governance
- Board Secretary

2.3 The Medical Director shall serve as the lead officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non- Executive members, the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than six times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- monitor progress on the quality and safety performance indicators set by the Board.

- provide oversight of the implementation of the ~~Clinical~~ Population Health & Wellbeing Strategy and review its impact, in line with the NHS Fife Strategic Framework and the ~~Care and~~ Clinical and Care Governance Framework.

- ensure appropriate alignment and clinical governance oversight with the emerging Programmes reporting through the Portfolio Board (i.e. Integrated Planned Care Programme; Integrated Unscheduled Care Programme; High-Risk Pain Medicine Programme);

- receive the minutes and assurance reports from the~~of~~ meetings of:
  - ~~Acute Services Division Clinical Governance Committee~~
  - Area Clinical Forum
  - Area Drug & Therapeutics Committee
  - Area Radiation Protection Committee
  - Cancer Strategy & Governance Group
  - Digital & Information Board
  - ~~Fife~~ Research, Information and Knowledge Oversight Group~~Committee~~
  - Health & Safety Sub Committee
  - ~~H&SCP Clinical & Care Governance~~IJB Quality & Communities Committee
  - Infection Control Committee
  - Information Governance & Security Steering Group
  - Medical Devices Group
  - NHS Fife Clinical Governance Oversight Group
  - NHS Fife Resilience Forum

- The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

- Receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations, including clinical governance reports and recommendations from relevant regulatory bodies, such as the Scottish Public Services Ombudsman (SPSO), Scottish Patient Safety Programme (SPSP) and~~which may include~~ Healthcare Improvement Scotland (HIS) reviews and visits.

- Issues arising from these Committees will be brought to the attention of the Chair of the Clinical Governance Committee for further consideration as required.

- To provide assurance to Fife NHS Board about the quality of services within NHS Fife~~.~~, including that effective adverse event management and organisational learning arrangements are in place and are compliant with Duty of Candour legislation.

- To undertake an annual self-assessment of the Committee's work and effectiveness.

- The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility.

5.2 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Clinical Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise ~~relevant risks on~~ the Corporate Risks aligned to that Committee~~Register~~ on a bi-monthly basis.

~~7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.~~

NHS Fife

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

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is brought as part of the third cycle of reporting on the corporate risks to the governance committees. It provides an update on the current status of the risks aligned to this Committee since the last report on 13 January 2023.

The Committee is invited to:

- Note the Corporate Risk detail as at 20 February 2023 at Appendix 1;
- Consider the Deep Dive Review at Appendix 2;
- Review all information provided against the Assurance Principles at Appendix 3;
- Consider and be assured of the mitigating actions to improve the risk levels;
- Conclude and comment on the assurance derived from the report; and
- Specify the risk (s) for a deep dive at the next Committee

2.2 Background

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

- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

NHS Fife Strategic Risk Profile

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

- No risks have been closed.
- No new risks have been identified.
- One risk has increased its target score (level and rating) - Primary Care Services
- One risk has reduced its current risk score (level and rating) - COVID 19 Pandemic.

The Committee is asked to note that the majority of corporate risks remain outwith risk appetite which reflects the continued heightened risk profile during a period of sustained operational challenge. This position was highlighted to the Board on 31 January 2023, when they recognised this deviation from our stated risk appetite for elements of service quality, patient experience, staff health and wellbeing, and financial decision making, in order to support service delivery and workforce.

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

Table 1

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

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities continues to face 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

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

Risks aligned to the Clinical Governance Committee

Table 2

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1	1	-	-	▲	• 3 - COVID 19 Pandemic • 5 - Optimal Clinical Outcomes	Risk 3 - COVID 19 Pandemic. Proposed reduction in risk level and rating from High 16 to Moderate 12. Mitigations updated for Risk 16 and 17.
To improve the quality of health and care services	1	-	-	-	◀▶	• 9 - Quality and Safety	
To deliver value and sustainability	2	1	-	-	◀▶	• 16 - Off Site Area Sterilisation and Disinfection Unit Service • 17 - Cyber Resilience • 18 - Digital and Information	

Risk Update

In reviewing their risks, owners were asked to give particular attention to target risk scores to ensure these realistically reflect the risk and the extent to which it can be mitigated locally in the current challenging climate.

Members are asked to note the change in relation to the following risk:

Risk 3 - COVID 19
In light of downward population numbers affected ,and the strong uptake of vaccination, it is proposed that the current risk level and rating decrease from High 16 to Moderate 12, which means the risk has reached its target level and rating.

This risk continues to be monitored closely at local and national level as the pandemic remains a significant threat, with the situation remaining quite uncertain over the coming months; there are some signals about future variants which may cause a spike in March 2023, and could potentially increase the risk level again.

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

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

At its last meeting on 13/01/23, this Committee commissioned the following deep dives:

Risk Title	**Committee Date**
COVID 19 Pandemic	3 March 2023
Optimal Clinical Outcomes	To be confirmed
Quality and Safety	To be confirmed
Off Site Area Sterilisation and Disinfection Unit Service	To be confirmed
Cyber Resilience	To be confirmed

The COVID 19 Pandemic Deep Dive Review is provided at Appendix 2.

Next Steps
The Corporate Risk Register will be updated between each committee cycle, including through review at the ROG and recommendations to EDG. This process will take note of committees' feedback, and use it to support improvement.

The ROG will also consider the developing Population Health and Wellbeing Strategy, and outputs of the SPRA process, in order to identify and recommend changes or additions to the Corporate Risks.

Focus will continue to be placed on enhancing the content of risk reports, including the deep dive component, to ensure that it:
- explicitly links to the risk;
- is relevant;
- is based on reliable evidence; and

- is sufficient to allow an overt conclusion to be reached on the assurance provided

2.3.1 Quality / Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Subject of the paper.

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement, including with the ROG on 1 February 2023, and EDG on 16 February 2023.

2.3.8 Route to the Meeting

- Neil McCormick, Director of Property & Asset Management on 20 February 2022
- Margo McGurk, Director of Finance & Strategy on 20 February 2023
- Dr Chris McKenna, Medical Director on 20 February 2023
- Dr Shirley- Anne Savage, Associate Director of Quality and Clinical Governance, on 20 February 2023
- Dr Joy Tomlinson, Director of Public Health on 20 February 2023

2.4 Recommendation

This report is presented to the Committee for

- **Assurance**.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Summary of Risks Aligned to the Clinical Governance Committee as at 20 February 2023
- Appendix No. 2 , Deep Dive Review: Corporate Risk 3 - COVID 19 Pandemic
- Appendix No. 3, Assurance Principles

Report Contact
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Appendix 1

Summary of Corporate Risks Aligned to the Clinical Governance Committee as at 20 February 2023

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk level/ rating by 31/03/23	Risk Level Trend	Appetite (High)	Risk Owner	Primary Committee
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	The autumn/winter vaccination programme has had strong uptake, providing protection from more severe consequences of COVID19. Implementation of new treatments for individuals at higher risk of adverse outcomes. Current levels of infection are demonstrating a downward trend. Monitoring continues of possible new variants at national level. Tailored support continues to be provided to Care Homes with positive staff or resident cases. Public communications programme to raise awareness of infection prevention	Mod 12	Mod 12	▲	Below	Director of Public Health	Clinical Governance

	hospital care and severe disease ,including death in a minority of the population.	and control measures across the region population cross the population. Deep dive prepared for March 2023 meeting of CGC.						
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	◀▶	Within	Medical Director	Clinical Governance

	To improve the quality of health and care services							
	Risk	**Mitigation**	**Risk Level**	**Target Risk Level by 31/03/23**	**Risk Level Trend**	**Appetite (Moderate)**	**Risk Owner**	**Primary Committee**
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	◄►	Above	Medical Director	Clinical Governance

To deliver value and sustainability

	Risk	Mitigation	Risk Level	Target Risk Level by 31/03/23	Risk Level Trend	Appetite (Moderate)	Risk Owner	Primary Committee
16	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review through Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) have agreed the design and the unit at St Andrews Community Hospital (SACH) should be operational by June 2023.	Mod 12	Low 6	◄►	Within	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	Considerable focus continues in 2023, with heightened threat level to improve our resilience to attack and ability to recover quickly. The primary mechanism for prioritising items is the response to the Network Information Systems Directive (NISD).	High 16	Mod 12	◄►	Above	Medical Director	Clinical Governance

	information required to operate a full health service.	review report May 2022.						
18	**Digital & Information (D&I)** 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	High 15	◄►	Above	Medical Director	Clinical Governance

Risk Movement Key

▲ Improved - Risk Decreased

◄► No Change

▼ Deteriorated - Risk Increased

Appendix 2

DEEP DIVE REVIEW: COVID 19 Pandemic for Clinical Governance Committee on 03/03/23

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

Root Cause (s)	strengthened. Not all actions identified from earlier pandemic preparedness exercises were fully implemented. Demand for personal protective equipment was significant and there were shortages early in the pandemic. Pressure on staff was unprecedented. The Scottish and UK COVID Inquiries are in progress and will identify what lessons there are for the future within their respective scope. The COVID19 response required additional programmes of work to be put in place by NHS Fife, including testing, contact tracing, enhanced support for vulnerable settings and restrictions on population movement**.** These remained in place until the national immunisation programme was fully established. National directions were given about the level of restrictions which required to be in place across the population. The pandemic has required multiple management actions, which have changed over time. Scotland's Strategic Framework sets out the strategic approach to the response and associated longer term harms. Although population cases remain relatively high, the majority do not require hospital care. Vaccine coverage is high, offering protection from the more severe consequences of illness. There is greater understanding of how to treat COVID19 cases and there are sources of information readily available for the public and healthcare staff. However, there is still potential for the COVID19 pandemic to cause pressures for the local healthcare system. There is a requirement to sustain actions that will protect staff, patients and the wider population from infection. These include continued attention to infection control measures, availability of PPE alongside training for staff, and support for the wellbeing of the workforce. The Deep Dive assessment is that the target risk level has been achieved at this point. It is important to note that this could change quickly. A new variant or mutation with significant vaccine escape would result in a rapid escalation of the risk; this is very hard to predict.		
Current Risk Level	Moderate 12	**Likelihood** 4 - Likely	**Consequence** 3 - Moderate
Target Risk Level	Moderate 12	**Likelihood** 4 - Likely	**Consequence** 3 - Moderate

Management Actions (current)		
Action	**Status**	**Impact on Likelihood/ Consequence**
Immunisation Winter booster 22/23. The winter campaign achieved the target uptake levels among care home residents and those 65 and over; flu & COVID booster vaccines continue to be on offer until 31/03/23, with outreach visits to areas with lower uptake in Feb 23.	**On track**	**Reduced consequence**
Population advice is available about travel, workplaces, ventilation, testing and staying at home and immunisation Coronavirus in Scotland. Advice is available for individuals on NHS Inform.	**Completed**	**Reduced likelihood**
Surveillance, contribution from GP surgeries across Fife contribute to the community surveillance programme, (Community Acute Respiratory Infections: CARI) as well as information gathered from hospital cases (Secondary Care Acute Respiratory Infections: SARI).	**On track**	**Reduced consequence**
Support for vulnerable settings is in place with range of guidance for healthcare and non-healthcare settings National	**Complete and ongoing**	**Reduced likelihood**

Infection Prevention and Control Manual and Fife specific advice is available on Blink Coronavirus (COVID19).		

Management Actions (future)		
Action	**Status**	**Impact on Likelihood/ Consequence**
Immunisation Spring vaccination programme is now being planned and will enhance protection for more vulnerable individuals in the population.	**On track**	**Reduced consequence**
Retention of surge capacity to deliver the nationally agreed response plan for new SARS-CoV-2 variants and mutations. This requires Boards to contribute to manage local cases and epidemiological investigation as well as engaging with the local population about communications. Surge capacity is also part of future immunisation planning.	**On track**	**Reduced consequence**
Pandemic preparedness and Major Incident planning require to be refreshed in line with national guidance once this is published. Local short life working group for Pandemic planning has been convened. Timescales for publication of national guidance are uncertain.	**On track**	**Reduced Consequence**
Scoping consequences of COVID19 infection across population will direct management actions for NHS Fife.	**Not Started**	**nil**

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

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

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

Committee Agenda

- Agenda items should relate to risk (where relevant)

Seek Assurance on Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

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

Year End Report

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

GENERAL QUESTIONS:

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

SPECIFIC QUESTIONS WHEN ANALYSING A RISK DELEGATED TO THE COMMITTEE IN DETAIL:

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

LEVEL OF ASSURANCE

Substantial Assurance	Adequate Assurance	Limited Assurance
Controls are applied continuously with minor lapse	Controls are applied with some lapses	Significant breakdown in the application of controls

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Population Health and Wellbeing Strategy – *Living Well, Working Well and Flourishing in Fife***
Responsible Executive:	**Margo McGurk Director of Finance and Strategy**
Report Author:	**Susan Fraser, Associate Director Planning and Performance**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Discussion
- Endorsement

This report relates to:

- NHS Board Population Health and Wellbeing Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Fife has been developing a new Population Health and Wellbeing Strategy which sets out the strategic direction for the organisation for the next 5 – 10 years. A draft of the strategy document is attached at Annex 1. Members of the Clinical Governance Committee are invited to discuss and endorse before the strategy is submitted to the NHS Fife Board for discussion and approval.

2.2 Background

Work on the strategy started in April 2021. Work has been interrupted through various points of the Covid-19 Pandemic, particularly the emergence of the Omicron variant in December 2021.

Development of the strategy was underpinned by a strategic framework that includes the vision- *'living well, working well and flourishing in Fife'* and four strategic priorities (Appendix 1).

A high-level milestone plan was agreed with the NHS Fife Board in March 2022 that has guided the subsequent development of the strategy. A core team has coordinated implementation of this plan and the following pieces of work have been delivered:

- An assessment of Fife population health and wellbeing led by the NHS Fife Public Health Team.
- Identification of key opportunities for NHS Fife by public and staff to make a positive impact on population health and wellbeing.
- A review of the 2016-21 Clinical Strategy. This review involved extensive engagement with operational and management teams across NHS Fife.
- There has been wide-ranging engagement undertaken with members of the public in Fife, community groups and the NHS Fife workforce. An external company, Progressive, was commissioned to support this work. A survey was undertaken which received 1300 responses. Further work was commissioned with Progressive to follow up with a range of focus groups and interviews to explore the findings of the questionnaire in more detail. The final report has been received summarising the findings of this engagement work and key points have been included in the strategy.
- Staff engagement continued with a Grand Round which provided background to the strategy to staff working across the organisation. Staff were invited to share their ideas on how we can improve population health and wellbeing across Fife communities. We have also provided regular updates and continued engagement with a wide range of colleagues across the organisation.
- The enabling strategies are in development and include the plans across Property and Asset Management (PAMS), Digital and Information (D&I), Workforce and Finance.

Regular papers and updates summarising this work have been shared with the NHS Fife Portfolio Board, the Board Governance Committees, the Area Partnership Forum and the Area Clinical Forum. Collectively this engagement has informed the development of the strategy. Drafts of the strategy have been developed and shared with a wide range of stakeholders and their feedback has been used to refine the output further.

2.3 Assessment

This draft strategy sets out the proposed strategic direction of travel for NHS Fife for the next 5-10 years. The timeframe for the strategy is a matter which will be considered by the full NHS Fife Board. The strategy is not a detailed blueprint of all our work but provides a statement of our key strategic priorities and how we will take forward plans

to deliver against the corporate objectives arising from them. The strategy will be dynamic and allow NHS Fife to be agile to respond to future emergent pressures and changing priorities on an ongoing basis.

The strategy document contains the following sections:

- **Foreword:** an introduction to the Strategy by the NHS Fife Chief Executive and NHS Fife Board Chair. This introduces the strategy acknowledging the need to support recovery from the Covid-19 Pandemic and the known challenges in the future. It makes a commitment to continued partnership working.
- **Overview**: provides a summary of how the strategy was developed.
- **Context**: this sets out some of the key areas that inform the strategy. These include:
    - Our drivers for change:
        - Continuing our ongoing recovery from Covid-19
        - Supporting our aging population
        - Responding to the differences in health and wellbeing across Fife
        - Doing more to prevent ill health
        - Using our resources well
        - Continuing to support joined up and seamless care across health and social care
        - Responding to the climate emergency
    - How the strategy aligns with other work
    - Our principles and values
- **Engagement:** how we have listened to the population of Fife and our workforce to help shape the development of the strategy and what we learned.
- **Strategic Priorities**: for each of the four priorities we have identified key ambitions, summarised what we were told through the engagement work, and given examples of what we plan to do. Each priority is supported with stories to make our work relatable to our public and our staff.
- **Implementation**: explaining how we will implement the strategy: a commitment to continue to work in partnership, involving our staff and the public, delivering a range of strategic programmes, ongoing monitoring and evaluation and regular communication to update all our stakeholders on what is happening.

The strategy is candid and acknowledges the legacy of the pandemic on our population, our staff, and our services. A key driver for change within the strategy is NHS Fife's ongoing recovery from the pandemic. We know that across our healthcare system, performance on a range of metrics, for example waiting times, is not to the

standard that we want it to be. Addressing this is a theme running throughout the strategy in line with national policy.

It is important to acknowledge this strategy doesn't simply seek to rebuild what was there before March 2020. Many of the challenges captured within the strategy predate March 2020 and the pandemic. For example, changing demographics and our aging population meant that services were not sustainable. The strategy seeks to find new ways of doing things, building on the learning from the pandemic and ensuring that we have a health service fit for the future.

Prior to presenting the strategy at the NHS Fife Board, we are continuing the engagement work with our staff. A plan to further communicate the strategy once it is signed off is also being taken forward. The table below summarises this work:

Activity	Timescale
Presentations to Local Partnership Forums	March /April 2023
Return visits to clinical teams, management teams and strategic programme boards to share the strategy and NHS Fife's priorities	February/March 2023
Drop-in sessions for staff held on teams and in person across and range of NHS Fife sites	February/March 2023
Develop Communications Plan developing a multi-channel communications plan for staff and the public post approval of the strategy (to be taken forward at the end of March onwards) 1. A follow-up Grand Round session 2. Exploring the creation of a short animation providing an overview of the strategy. 3. Online content for staff link and webpages	 29 March 2023 (tbc) April 2023 April/May 2023

A delivery plan, which essentially creates the corporate objectives for 2023/24 and the years beyond that, is also being developed.

2.3.1 Quality / Patient Care

The strategy places a commitment to the delivery of high-quality health and care services across Fife. The strategy sets out how we will seek to address this whilst recognising that change will be required to deliver this.

2.3.2 Workforce

A key priority of the strategy is supporting improvements to staff experience and wellbeing to enable greater resilience and support across all our workforce. The draft strategy outlines a series of commitments to the NHS Fife workforce.

2.3.3 Financial

A key driver for change is ensuring that NHS Fife is financially sustainable in the medium and longer term. We know that we will need to continue carefully manage our resources and the strategy provides the NHS Fife Board a framework to support decisions about the allocation of our financial resources.

2.3.4 Risk Assessment / Management

There has been ongoing risk assessment throughout the development of the strategy and reported through the organisational risk management processes. Further risk assessment will be undertaken as part of the implementation of the strategy across key programmes of work and this will be monitored on an ongoing basis.

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

This strategy recognises the NHS Fife commitment to equality and diversity and places these at the heart of everything we will do. The impact of health inequalities and NHS Fife's role as an anchor institution is outlined in the strategy as a key driver for change. Collectively the priority actions outline the steps we will take to reduce the impact of inequalities and how we can achieve this. As we evaluate the impact of the strategy, we will be monitoring and assessing the impact of inequalities over time.

2.3.6 Climate Emergency & Sustainability Impact

A key driver for change captured within the strategy is addressing the impact of the Climate Emergency.

2.3.7 Communication, involvement, engagement and consultation

There has been good engagement process throughout the development of the strategy that has captured the views of members of the public who use our services and our staff. We commissioned Progressive to undertake a survey of our staff and the public. This was then followed up with focus groups and in-depth interviews with the public. We have presented on the strategy across a wide range of forum's and gathered views from across the organisation. Collectively we have engaged with over 2000 staff and members of the public. Engagement work remains ongoing, and we are continuing to share the draft strategy with staff prior to submission to the NHS Fife Board.

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.

- Portfolio Board 12 January 2023
- Portfolio Board 9 February 2023
- Area Partnership Forum 25 January 2023

- Area Clinical Forum 2 February 2023
- NHS Fife Board Development Session 28 February 2023
- Public Health and Wellbeing Committee 1 March 2023

Recommendation

The Committee is asked to:

- Take **Assurance** from the process undertaken to develop the NHS Fife Population Health and Wellbeing Strategy and the ongoing engagement work.
- **Endorse:** Members of the Committee are asked to review and endorse this strategy for discussion and final approval at the March NHS Fife Board Meeting.

3 List of appendices

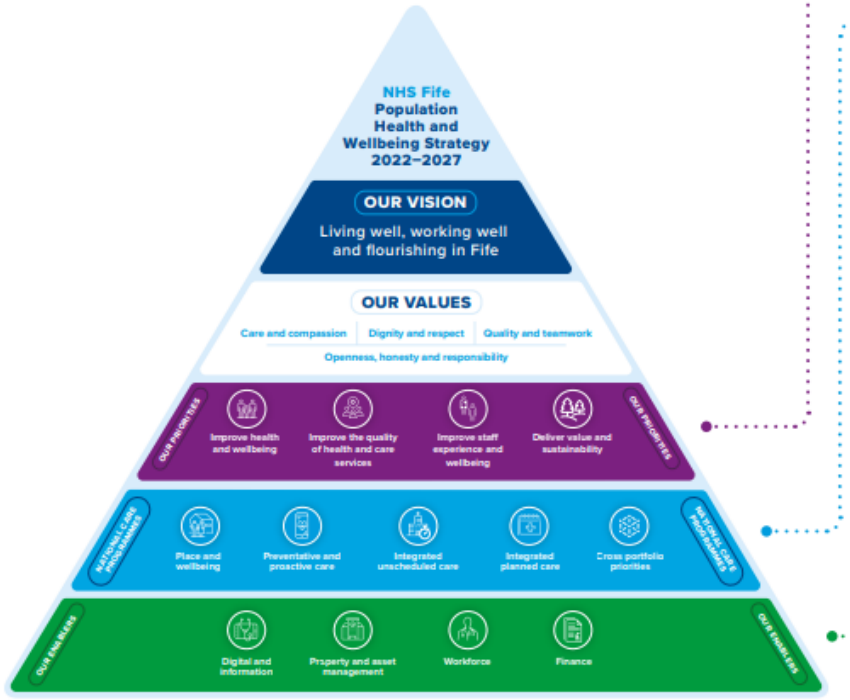
Appendix One: Strategic Framework
Appendix Two: Draft NHS Fife Population Health and Wellbeing Strategy

Report Contact
Tom McCarthy
Portfolio Manager
Email: tom.mccarthy@nhs.scot

Appendix One: Strategic Framework 2022-27

Our Strategic Framework 2022–2027

This is our strategic framework, developed by our staff and built on our vision and values.



OUR PRIORITIES

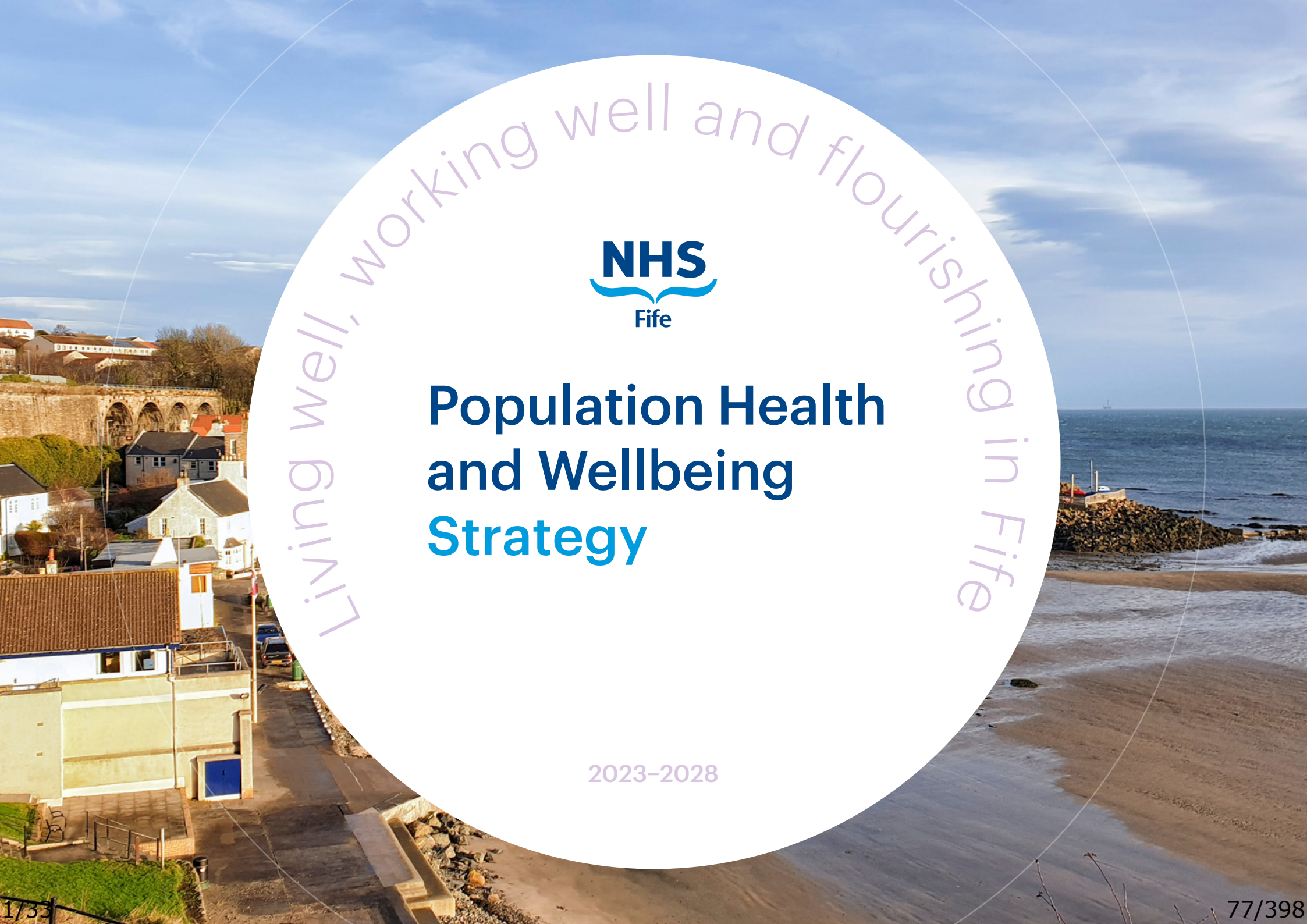
To improve health and wellbeing	Helping people to stay well at home and addressing inequalities and access.
To improve the quality of health and care services	Providing the safest and best possible services to the people of Fife.
To improve staff experience and wellbeing	Valuing and looking after our staff.
To deliver value and sustainability	Ensuring our services are sustainable, relevant and provide the best use of our resources.

NATIONAL CARE PROGRAMMES

Place and Wellbeing	The aim is to support partnership working to improve health and wellbeing and reduce health inequalities of a population within a defined local geography.
Preventative and Proactive Care	The aim is to proactively keep people well, independent and in the most appropriate care setting for their needs.
Integrated Unscheduled care	The aim is to provide support to those people in need of urgent health and/or social care.
Integrated Planned Care	The aim is to support the effective implementation of the Remobilise, Recovery, Redesign Framework (2020).

OUR ENABLERS

Digital and Information	To improve the care and wellbeing of people in Fife by making the best use of digital technologies in the design and delivery of services.
Property and Asset Management	To ensure the infrastructure is fit for purpose and supports the delivery of patient care and services across Fife.
Workforce	To ensure a sustainable, fulfilled workforce to deliver innovative and high quality patient care.
Finance	To support investment and disinvestment which delivers prioritised and impact assessed financial arrangements.



NHS Fife

Population Health and Wellbeing Strategy

2023–2028

FOREWORD

Welcome from our Chief Executive

We aim to deliver excellent care and improve population health and wellbeing for the people of Fife

Carol Potter
Chief Executive

We have developed this new strategy through extensive engagement with our communities, staff, patients, and partners.

This work has highlighted what matters to the people of Fife when they need health care services and how communities want to be supported in maintaining and improving their health and wellbeing.

This strategy does not set out a series of detailed actions. Instead, it is a declaration of our vision and intent to prioritise health inequalities and support improvement in the health and wellbeing of our citizens. Through annual delivery plans, the implementation of the strategy will be taken forward in the context of a range of drivers for change.

The key will be our continuing recovery from the global pandemic which has significantly impacted our communities and their physical and mental health and wellbeing. The pandemic has also been very challenging for our staff and the delivery of our services. We anticipate this impact will continue for the foreseeable future.

Looking ahead, we will continue working towards providing high-quality care whilst addressing the challenges in the length of time many patients wait to receive their care. Our staff have continued to demonstrate their extraordinary commitment to public service, working under significant and sustained pressure for a period longer than anyone could have predicted at the outset.

This is an interactive document
The top toolbar allows you to navigate through the different sections of the guide.

We face an uncertain and challenging financial position as we emerge from the pandemic and redesign our services to fit the future needs of our communities.

It is widely recognised across health and social care and by professional organisations, including Audit Scotland, that the NHS was not financially sustainable before the pandemic. However, our challenges have been exacerbated by its impact and legacy. NHS Fife, like all NHS Boards, must plan an effective response to the significant capacity and supply issues in key areas of our workforce.

This new strategy acknowledges the compounding pressures that the financial and workforce challenges ahead of us will bring.

We are proactively preparing to deliver financial sustainability over the medium term and embracing all opportunities to provide new ways of working and developing new staff roles in supporting us through these most challenging times.

We know that recovery will not be achieved in the short term, but we remain ambitious for longer term recovery. We will work to secure a positive legacy from the pandemic, and this strategy underpins our approach.

Central to all our work will be a focus on prevention and early intervention. We know that our health and wellbeing are determined by many factors – education, housing, and employment, to name just a few – and as far back as 1948, the World Health Organisation recognised that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".

We aspire toward being one of the most trusted and responsive health systems in the country, developing and delivering services that enable all of our citizens to "live well, work well, and flourish in Fife", and we look forward to working in partnership with other public sector bodies, third sector, industry, academia, and our communities across Fife to deliver this vision.

Overview

The building blocks of our strategy

Our vision
Living Well, working well and flourishing in Fife

Our values

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

Our principles

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

Our strategic priorities

1. Improve health and wellbeing

We will work to close the inequality gap in communities across Fife, ensuring that all people of Fife can flourish.

2. Improve the quality of health and care

We provide the safest and best possible services to the people of Fife.

3. Improve staff experience and wellbeing

We value and look after our staff.

4. Deliver value and sustainability

Ensuring our services are sustainable and appropriate and using our resources best.

CONTEXT

Living well, working well, and flourishing in Fife

The population of Fife and its healthcare needs are changing. Here we describe some key factors that explain how health and care are changing, how this strategy links with other work, and the guiding principles underpinning our decision-making.

Why we need to change

Recovery from the pandemic

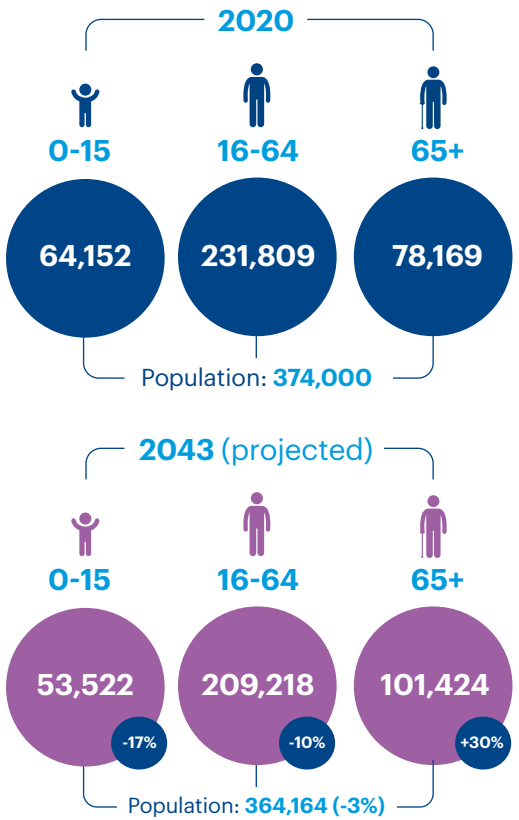
The impact of the pandemic has touched all parts of health and care services. The virus meant difficult decisions were made to protect patients and staff. It will be some years in the future before the legacy of the pandemic is fully understood.

The pandemic has taught us how things can be done differently, at a pace and in an agile way. We have seen how we can use technology to deliver virtual consultations by phone or video call as a part of a blended approach to clinical service delivery. Looking ahead, we want to build on what has happened in the last three years and continue innovating to support service delivery and provide high quality care.

Due to the pandemic, many patients are now experiencing longer waits for treatment and care.

There are challenges in responding to this increased demand; we must be creative in addressing this.

Our ageing population



Fife's population is expected to grow older. By 2043, there will be a 30% increase in those aged 65+. We know that this age group is likely to experience multiple health conditions with increasing frailty. People in the 65+ age group are the highest users of healthcare.

We want to ensure that people can live well as they age, they are supported to make decisions about the care they want to receive and ultimately, we want to ensure that people can receive good end of life care. To achieve this, we need to make changes to how we are currently delivering services so that they remain sustainable in the future.

Differences in health and wellbeing across Fife

Our recent Director of Public Health Annual Report highlighted that many factors influence health and wellbeing. Some cannot be changed, such as our age or genetics, while others can be modified such as our diet. Levels of obesity, alcohol intake, lack of exercise, smoking, and experience of childhood adversity, are higher in Fife than they should be for good health.

Our health and wellbeing is also influenced by the conditions in which we grow up, live and work. The "building blocks" of community health and wellbeing include affordable, secure, and quality housing; stable, well-paid work; accessible childcare; training and education.

These shape the conditions in which we work, live, and grow. When some or all of these building blocks are missing, community health and wellbeing declines. For example, not having enough income can lead to constant worrying about making ends meet. Over time this can then put people at increased risk of illnesses such as heart disease.

We know that people living in poverty have shorter lives. In 2016–2020, men from the most deprived areas of Fife lived on average 10 years less than men in the least deprived communities. These differences in health outcomes are described as health inequalities and are to a large extent avoidable. Unfortunately, the recent cost-of-living crisis is forecast to widen health inequalities even further.

Supporting health, wellbeing and reducing inequalities

As a large organisation connected to our local area and community, we recognise we can make a positive contribution as an Anchor institution.

As an anchor institution, we can influence the health and wellbeing of people in Fife simply by being there. But by investing in and working with others locally and responsibly, we can have an even greater impact on the wider factors that make us healthy.

However, we cannot directly influence all the building blocks for good health and wellbeing. That is why we need to work in partnership with other organisations, such as the Fife Health and Social Care Partnership, Fife Council, Scottish Government, and the voluntary sector.

Our role as an anchor institution

We employ people from local communities through fair and equitable employment practices and pay a living wage.

We use our land and buildings to support local communities and influencing health and wellbeing in education, housing and employment.

We deliver prevention services such as effective healthy weight programmes, vaccination, and screening services.

Sally's story

In 2022 we participated in a work experience initiative to provide young people aged 16-24 from our local communities with valuable work experience and development opportunities.

Sally started her six-month placement within the Procurement team, liaising with various multi-disciplinary ward-based staff to ensure the provision of critical products needed to deliver effective patient care.

By the end of the placement, Sally's self-confidence had increased and the work experience gained, allowed her to actively apply for a permanent post.

How we work across Health and Social Care

We have legislation, the Public Bodies (Joint Working) (Scotland) Act 2014, which requires health boards and local authorities to collaborate to integrate the provision of health and social care services known as 'health and social care integration'. Fife Health and Social Care Partnership provides a wide range of delegated health and care services for NHS Fife and Fife Council.

In 2020, the Scottish Government undertook an Independent Review of Adult Social Care. In response to the review, the Scottish Government has committed to establishing a National Care Service by 2026. We will work with Fife HSCP and others to ensure that people experience joined-up care, in the right place, at the right time, both now and in the future.

Achieving financial sustainability

Whilst planning services, we bring together operational, workforce and financial objectives to ensure the most effective allocation of resources across our health system. The finite nature of our financial resources will inevitably require us to prioritise areas for investment and disinvestment.

With increasing demand for our services, we must look at ways to deliver more. We will ensure we drive the best value from our resource allocation for the people of Fife.There are likely to be important choices ahead, ensuring that we focus on the areas of service and support which drive the most health benefit to the people of Fife.

Climate change and sustainability

We recognise our duty to act to address climate change, working towards aligning ourselves to the national Sustainability Strategy and achieving the targets set within this and our approach to sustainable development.

As both an anchor and a public sector organisation, we must look towards the tools at our disposal.

Nationally the Scottish Government has published the NHS Scotland Climate Emergency and Sustainability Strategy 2022-2026. This sets out five key themes and a range of actions to support the achievement of 'Net Zero'.

Our objectives mirror the national strategy. Examples of our work include:

- Identifying ways to heat all NHS buildings using renewable resources by 2038.
- Reducing emissions from propellant in metered dose inhalers.
- Promoting sustainable travel.

We have developed a local action plan to support the delivery of these objectives. This work will impact all aspects of our strategy.

How this strategy aligns with other work

Our strategy aligns to a range of local, national and partnership plans reflecting national policy and local ambitions.

Population Health and Wellbeing Strategy 2023–2033

NHS Fife

- Cancer Framework
- Pharmacy and Medicines Strategy
- Workforce Strategy
- Digital and Information Strategy
- Property and Asset Management Strategy
- Research, Innovation and Knowledge Strategy
- Green Space Strategy
- Medium Term Financial Plan

Partnerships

- Plan for Fife
- Fife Health and Social Care Parnership: Strategic Plan for Fife
- Food for Fife Strategy

National

- NHS Scotland Recovery Plan
- National Clinical Strategy
- Value Based Healthcare
- Public health approach to prevention and the role of NHSScotland
- Women's Health Plan: A plan for 2021-2024
- NHS Scotland Climate Emergency and Sustainability Strategy 2022-2026

A foundation for Improvement

An enduring focus on the performance and sustainability of our services and on improving population health and wellbeing.

Principles for the strategy

Our principles underpin the development and implementation of the strategy. They commit us to:

1. Support people to help each other in the **communities** that they live and work.
2. **Empower** people to take control and manage their own care.
3. Embed **prevention** and early intervention into the delivery of healthcare services.
4. Ensure the **wellbeing** of communities and staff is central to everything we do.
5. Act with **kindness** embedding it into the systems and culture of our organisation.
6. **Listen** and involve people in how we design, deliver and improve everything we do

Our values

We treat people using services and provide our workforce with the care, compassion, dignity and respect they expect and deserve.

We believe in an open and honest culture. Everything we do is delivered through teamwork, and continued quality improvement is core business.

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

ENGAGEMENT

Listening to what matters to you

We discussed with our staff and the public ways to improve health and wellbeing, the impact of the Covid-19 pandemic, and their experience of our services.

Who we spoke to

We have completed extensive engagement with our staff and communities across NHS Fife.

We spoke to over 2000 people.

1300 members of the public.

200 staff sessions to talk about inequalities.

We have spoken at over **60** meetings about the strategy.

We reviewed over **350** patient stories.

Presented to over **550** staff about the strategy.

What we learned

Following extensive engagement with our staff, service users and the communities we serve, a number of consistent themes started to emerge.

People of all ages spoke about how the pandemic affected their mental health and the challenges of accessing timely support during this period.

Patient-centred care

The perception of many respondents was that the focus of health care services has changed to managing the volume of patients rather than providing individual care.

Lack of joined-up care was also a recurring theme, with patients expressing concerns about communications between services and other health boards.

Access and waiting times

We heard first-hand experiences of pressure in the health and care system including the impact of needing to wait for care and difficulties in making appointments. In some parts of Fife, it was commented that it is difficult to register or make a GP appointment.

Geography was also highlighted, particularly for some more rural and isolated communities. For those who do not have access to a car, travelling around Fife is difficult. Participants spoke about the challenges of taking a bus to and from hospital appointments.

Health and wellbeing

Improving health and wellbeing was highlighted as a key priority and ensuring individuals were able to access services to actively help and support their own physical and mental health.

Some of the barriers identified included cost, time and uncertainty around what support was available.

There was geographical variation identified, for example from those living in more rural communities feeling disadvantaged in being able to access services near where they live.

The impact of the pandemic was also highlighted as having a negative impact on health and wellbeing and access to services.

Communication

The importance of good communication between staff, patients and clinical teams was also highlighted. With suggestions for improvement including more regular updates, more accessible information and better conversations between patients and their clinical team.

Workforce

Members of the public spoke positively about our friendly, caring and professional staff, while recognising the pressure they were under in relation to staffing levels.

Staff also highlighted the importance of focussing on staff recruitment and retention to allow us to meet increasing demand while continuing to deliver patient-centred care.

Innovative ways of working

In response to the global pandemic, we had to look at doing things differently to ensure that those with clinical needs could continue to access health care in a safe and sustainable way.

Technology played a huge part in enabling clinicians and their patients to continue engaging safely through the various lockdowns and restrictions.

As we look ahead, these new ways of working adopted in the pandemic will continue to be part of our offering, with patients having options on how they wish to engage with clinical teams.

This new blended approach will include telephone triaging, video conferencing consultations, and online self-referral in tandem with face-to-face appointments with a range of health care professionals.

A recurring theme throughout our engagement was the recognition that technology was seen as a vital element in delivering a modern, fit-for-purpose health and care service, combined with face-to-face appointments, helping to make access to services easier and more flexible for patients.

interactive infographic
Click the icons for more information.

OUR STRATEGIC PRIORITIES

Improve health and wellbeing

Improve staff experience and wellbeing

Improve the quality of health and care services

Deliver value and sustainability

PRIORITY 1

Improve health and wellbeing

We will work to close the inequality gap in communities across Fife ensuring that all people of Fife are able to flourish.

Ambitions*

A Fife where we:

1. live in flourishing, healthy and safe places and communities.
2. thrive in our early years.
3. have good mental wellbeing.
4. reduce the use of and harm from alcohol, tobacco, and other drugs.
5. have a sustainable, inclusive economy with equality of outcomes for all.
6. eat well, have a healthy weight and are physically active.

*Based on Scotland's 6 public health priorities.

What we were told

Throughout our engagement with our colleagues and the local communities we serve, we heard about the challenges people living in Fife faced in maintaining and improving their physical and mental health and wellbeing.

Addressing health inequalities was also a recurring theme with a drive and motivation expressed to create a Fife where everybody can thrive.

It was acknowledged that health inequalities across communities and the general population are caused by a range of factors, including where we are born, live, work and grow. These conditions influence our opportunities for good mental and physical health.

As an anchor institution, we are working with the public, third and independent sector partners as well as local companies and employers to help address these issues and provide opportunities for all to thrive.

One of the most effective things we can do for peoples' health is to help them financially.

There are already examples of good practice in this area. Many of our services routinely ask people about their financial circumstances and, where appropriate, refer them for benefits advice. This work has shown clear evidence that by supporting people to maximise their income can have a direct and positive impact on their physical and mental health.

What we will do

Current examples of local initiatives include:

- We will scale up the work supporting people to access benefits advice so that more people, where appropriate, can access financial and benefits support.
- Ensuring universal access to immunisations including influenza and COVID-19.
- In line with the UN Convention on the Rights of the Child, we will support every child to have the best possible health. Examples include promoting breast-feeding and helping to address child poverty.
- Improving awareness of the range of mental health and wellbeing support across Fife amongst NHS staff and the public.
- Improving mental health services for individuals struggling with substance misuse through closer working with the community alcohol and drug partnership.
- In line with the NHS Fife Greenspace Strategy, we will use NHS Fife's buildings and land to support communities to improve health and wellbeing. For example, by making our buildings and land available for the voluntary sector to support their activities where appropriate.
- We will support people to make healthier food choices and maintain their physical activity, particularly in older age, enabling them to stay independent and healthier for longer.
- Collaborating in regeneration projects like the River Leven programme.

Julia's story

Julia lives in a three-bed private let in East Fife with her three children: Ben (9-months), Amy (4) and Sam (8). Julia's health visitor asked her how she was managing and Julia shared that she was struggling to make ends meet.

Recognising that Julia might be entitled to other benefits she was not currently claiming, her Health Visitor referred her to the Money Talk Team for information and advice. The Money Talk Team is run by the Citizens Advice and Rights Fife (CARF) and aims to increase financial awareness, maximise incomes and improve health outcomes for people.

The team identified that Julia was entitled to Universal Credit. They also explained that this is a qualifying benefit allowing people to apply for other benefits such as a Council Tax reduction.

As well as advising on benefits, the team provided her with information on practical ways to reduce her outgoings such as energy costs.

> Thank you [Money Talks Team] for explaining everything, you made it so easy to understand and didn't treat me like a child. I feel more confident as I know I will have more independence now I have some money coming in.
>
> **Feedback from a client of the Money Talks Team**

Citizens Advice & Rights Fife

Jack's story

Jack is a 78-year-old widower with emphysema. He was admitted to the hospital following a fall at home. During Jack's admission, the healthcare team fully assessed his needs. They identified that Jack lives alone without any family nearby. His hobbies include gardening and walking, but his shortness of breath makes this challenging.

The healthcare team suggested Jack visit The Well, a drop-in service provided by the Fife Health and Social Care Partnership in community venues and online. It provides information and general advice to help people stay well and independent within their local community.

The Well provided Jack with information on a community walking group which will allow Jack the opportunity to meet new people whilst doing some gentle exercise. Not only does this help Jack continue to do what he enjoys by keeping physically active, but it may also reduce the risk of another fall and being readmitted to the hospital. Jack also raised a concern regarding his finances. The Well referred to Citizens Advice and Rights Fife to ensure he receives the benefits he may be entitled.

> We need services to change their models and access approach. Work in areas not traditionally health and also consider other methods.
>
> **NHS Fife staff member**

PRIORITY 2

Improve the quality of health and care services

Providing the safest and best possible health and care services to the people of Fife.

Ambitions

1. Provide high quality patient centred care.
2. Deliver services as close to home as possible.
3. Less reliance on inpatient beds by providing alternatives to admission to hospital.
4. Timely access to emergency, elective and community care services based on clinical need.
5. Prevent and identify disease earlier.
6. Support the delivery of seamless, integrated care and services across health and social care.

What we were told

The pandemic led to many changes in health and care services. During our engagement work with members of the public and staff we heard that their experience is that many of the services they work in or rely upon have been negatively impacted.

In common with other health boards across Scotland, we know that our performance standards have deteriorated. This is evident in longer waits in the Emergency Department and for diagnostics and treatment.

We have an ageing population who are becoming frailer with more medical conditions which results in more demand on existing services. We must identify new ways of working that do not solely rely on access to hospital services and admission to hospital.

What we are going to do

- Redesign urgent and emergency care to reduce our reliance on the Emergency Department and in-patient care.
- Improve cancer care, for example by continuing to develop our Rapid Cancer Diagnostic Service.
- Provide a world class elective orthopaedic service through the National Treatment Centre – Fife Orthopaedics.
- Further develop our day surgery service at Queen Margaret Hospital.
- Increase the level of ambulatory services (care provided without being admitted to hospital) across Fife.
- Focus on waiting times and support people, where appropriate, to wait well for their procedure.
- Continue to invest and develop in new technologies such as robot assisted surgery to provide high quality care.

John's story

John is a 53-year-old man who suffered from unexplained weight loss and feeling nauseous. He made an appointment with his GP, who carried out several blood tests. This highlighted some abnormal results, and following a discussion with his GP, it was agreed that he should be referred to the Rapid Cancer Diagnostic Service. This service investigates patients with possible symptoms that may be caused by cancer and aims to confirm or exclude a cancer diagnosis within 21 days from a referral by a GP.

The day after John was referred, he received a phone call from the Advanced Clinical Nurse Specialist, as this is a nurse-led service.

They spoke through John's blood test results, explored John's symptoms further and recommended that John have a Computerised Tomography (CT) scan.

A CT scan and consultation was booked over the phone to address any concerns John had.

48 hours after the CT scan, John received a phone call from the service, who explained that he didn't have any sign of cancer. However, the tests did show severe inflammation in the small intestine.

John was given a treatment plan and a further follow-up CT scan was arranged in 3 months to check the inflammation was improving.

> I personally want to thank the Rapid Cancer Diagnostic Service for such great service – thank you NHS Fife.
>
> **Feedback from John on the service he received**

Dorothy's story

Dorothy is 86 years old and lives in Sheltered Housing. Dorothy was recently discharged from hospital following a fractured hip. Dorothy has a mild cognitive impairment (she can sometimes get confused) but can live independently at home. During admission, she has been advised to use a walking stick to help her move around safely. Her 65-year-old daughter Louise has been supporting her with managing her money, general domestic tasks, and some meal preparation.

On Thursday afternoon at around 4pm, Dorothy had another fall while her daughter was there. Louise helped her Mum to get back into a chair. However, Dorothy continued to complain of discomfort in her hip that was previously broken.

Fearing that her Mum had broken her hip again, Louise contacted NHS 111 for advice on what to do next. They directed her to attend the hospital to get assessed. As Louise called 111, they can bypass A&E and Dorothy is admitted directly to an assessment unit.

The team on the assessment unit reviewed Dorothy, and she remained in the unit overnight. The following morning Dorothy was assessed by the frailty team, who confirmed no fracture. The frailty team recognise that Dorothy would benefit from some further rehabilitation to see if they can support Dorothy to continue to live at home independently.

They review Dorothy's care with a social worker in the hospital who suggests accessing a Short-Term Assessment and Reablement (STAR) bed which Fife Health Social Care Partnership provides in conjunction with care homes across Fife. This service helps people return to their homes after a short stay in the hospital. A STAR bed is identified, and Dorothy is discharged on a Friday afternoon. She is supported to recover further and later returns to her home with a support plan to help her continue living as independently as possible in her own home.

Short-Term Assessment and Reablement (STAR) bed helps people return to their homes after a short stay in the hospital.

PRIORITY 3

Improve staff experience and wellbeing

Valuing and looking after our staff.

Ambitions

Our workforce:

1. is inclusive and diverse, reflecting Fife's communities.
2. experiences compassionate leadership in a culture that supports wellbeing.
3. is supported to develop new skills that help improve care for patients.
4. is heard and at the heart of transforming services.
5. works in partnership across health and social care, recognising interdependencies.

What we were told

During the engagement work the importance of our staff has been repeatedly highlighted. We heard that people using our services have confidence in NHS Fife staff. We also heard that Covid-19 has had an enduring impact on our workforce who have worked on the frontline responding to the pandemic.

NHS Fife has developed a 2022-2025 workforce plan which sets out how NHS Fife will respond to these workforce challenges. This plan aligns across our Fife partners and details how:

- We will develop our workforce to reflect changing clinical services.
- The workforce will be supported as services are transformed.
- Sustainability of the workforce to support clinical services will be achieved.

What we are going to do

We will:

- Develop and launch a new Leadership Framework with a continued focus on compassionate leadership and an open, transparent and nurturing culture.
- Promote a range of career pathways with a focus on developing our workforce,
- Expand and enhance our employability programmes across Fife including a range of foundation and modern apprenticeships.
- Continue to support our staff with their practical health and mental wellbeing
- Set new international recruitment targets annually for Fife, focusing on key areas of shortage over the next 5 years.

Developing our workforce: creating new nursing roles

We are creating a new Assistant Practitioner role to support our nursing workforce. These new roles are integral to the wider nursing team and enable registered nurses to focus on more complex clinical care.

We are working with Fife College to provide a one year fully funded training programme to support training and recruitment of high-quality nursing care across NHS Fife.

> “Fife College is delighted to be working in partnership with NHS Fife in delivering this exciting new course.

Rebecca’s story

After having children in her teens, Rebecca* started college in her early 20s, thinking she might train to work in nursery education. But soon decided it wasn’t the right role for her. Rebecca saw jobs advertised in maternity services and she jumped at the opportunity to use her skills in a different way.

Rebecca never imagined that she would love it as much as she did. After about six months, she realised she wanted to be a nurse and enrolled in a Paediatric nursing course. Rebecca qualified as a paediatric nurse and was offered a job in the Neonatal Unit, which she absolutely loved.

Following her first role in nursing, Rebecca progressed in Fife to the junior charge nurse role, but her passion lay with working with babies so she specialised as an Advanced Neonatal Nurse Practitioner.

> “I’ve been an Advanced Neonatal Nurse Practitioner for seven years, and it has been a challenging but amazing career. I feel very blessed to work with all the families and babies that I have. It is their stories that inspire me.
>
> **Rebecca talking about her career as a nurse**

Helen's story

Helen's journey into working in healthcare has been an unconventional one. Before the pandemic, she worked in media production, however during the pandemic, work in this area was severely impacted by lockdown, and she had to explore new opportunities for employment.

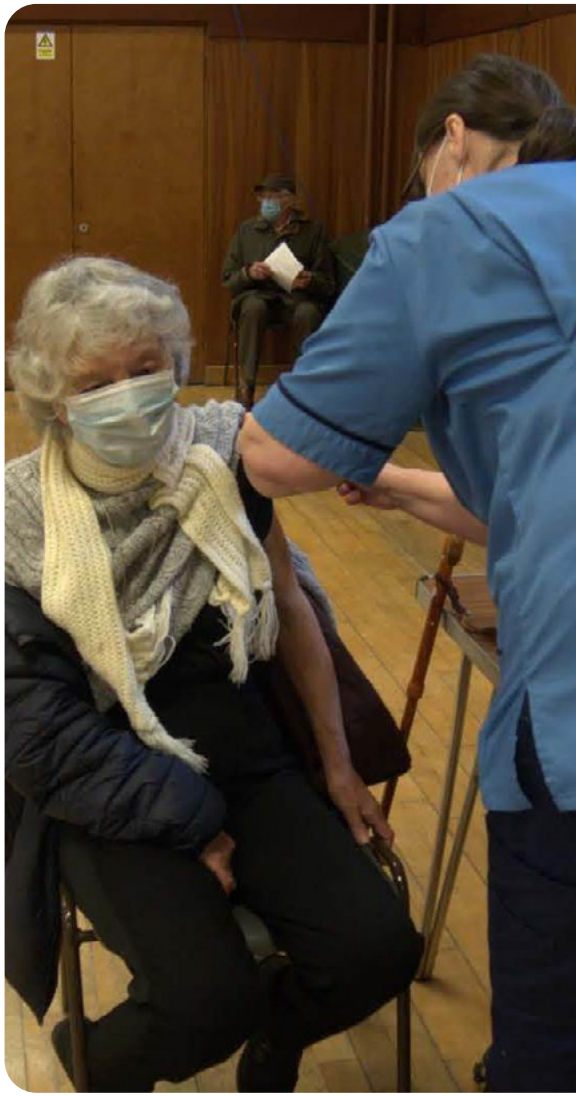
She began her NHS journey as a Venue Support Worker at the vaccination clinics and loved this experience. The team she worked with were great, and she admired how much everyone worked together with a common purpose and drive and commitment to deliver the ambitious vaccination programme.

Her healthcare support worker colleagues encouraged her to join the NHS Fife nurse bank. She joined the bank as a Healthcare Support Worker and never looked back.

Helen started working at Stratheden Hospital and was inspired by the team she was working with. She realised that she was working in a role she was truely was passionate about and incredibly rewarding.

After working for a year on the nurse bank at Stratheden, she decided to make the leap and become a full time health care support worker with the intention to train to become a mental health nurse.

> The NHS helped me when I needed it most, and I've unexpectedly found a passion and career path where I feel like more than just a number.
>
> I feel appreciated, valued and needed. I am excited to see where the next few years will take me.
>
> **Helen talking about her career path**



PRIORITY 4

Deliver value and sustainability

Ensuring our services are sustainable, relevant and provide the best use of our resources.

Ambitions

1. **Provide the right services in the right places with the right facilities.**
2. **Ensure the best use of our buildings and land.**
3. **Reduce energy usage and carbon emissions, working toward carbon neutral by 2040.**
4. **Deliver our capital programmes for primary care, mental health, and acute services creating high quality environments for patients and staff.**
5. **Deliver sustainable and effective resource allocation that supports value-based healthcare.**

What we were told

During the pandemic, we rapidly changed how we deliver services that in some cases reduced the need to travel to access care.

We should embrace this shift to alternative ways of delivering and supporting healthcare using technology but ensure options remain for more traditional methods of service delivery where required.

We should offer more healthcare closer to the community including outreach services which can be accessed more easily and promptly.

Members of the public and our staff felt that technology could be better used to help services become more efficient and support better sharing of information internally between services and externally between health boards and other partners.

We continue to focus on sustainability and working towards being carbon neutral by changing to the way we heat our buildings, reducing travel and reducing waste.

With current financial pressures, we need to ensure that we continue to use our funding as effectively as possible and invest in sustainable solutions.

What we are going to do

- Maximise the use of our buildings and land in line with service needs.
- Develop new buildings to support service delivery such as new Health and Wellbeing Centres in Kincardine and Lochgelly.
- Redesign and develop mental health services in Fife, including modern inpatient and community-based services.
- Develop services using a structured approach to identify financial efficiencies. For example, through careful procurement of supplies and use of generic medications.
- Become an organisation providing more responsive care using technology, developing digital solutions such as virtual appointments, electronic access to test results and growing our use of data to support planning and delivery of care.
- Reduce our energy usage through use of zero carbon technology such as increased usage of solar panels and redesigning how we heat our buildings.
- Lower the environmental impact of travel by making the use of technology (virtual appointments and virtual working), supporting sustainable travel (walking, cycling and public transport) and investing in electric and low emissions vehicles.
- Apply the principles of value based healthcare to support achievement of financial sustainability.

National Treatment Centre – Fife Orthopaedics

Nationally the number of people requiring orthopaedic services has been growing. This, combined with the development of innovative new approaches to care and treatment has provided an oppurtunity for NHS Fife to open the first national treatment centre in Scotland.

The development of the new National Treatment Centre on the Victoria Hospital site wil provide a purpose-built orthopaedic centre. An increase in the number of theatres, additional outpatient space and dedicated wards will mean we can significantly increase the capacity for patient care for people in Fife and across Scotland.

Building on our international reputation as a centre of excellence in orthopaedic surgery including pioneering hip and knee replacement day surgery, we are taking the opportunity to integrate a range of technology into the new build to facilitate teaching research and innovation to enhance the patient experience and outcomes.

Insert quote from first minister

Towards Net Zero: improving the energy efficiency of our buildings

NHS Fife is working towards achievement of 'Net Zero carbon' by 2045. Heating and lighting our buildings makes up a large proportion of the Board's carbon emissions. Taking an energy efficient approach to improving buildings is vital to minimise energy demand and reduce emissions. Working with Scottish Government NHS Fife has secured investment in energy saving measures. This includes installing LED lighting; improving the fabric of buildings such as installing draft proofing and insulation; and installing solar panels to generate electricity. As part of this work solar panels have now been installed on a range of NHS Fife sites.

The benefits of this work include reducing our energy usage which leads to financial savings, reducing the environmental impact of buildings by supporting achievement of Net Zero and helping to maintain buildings across the NHS Fife estate.

IMPLEMENTATION

How we will deliver the strategy

Supporting the implementation of our strategy with clear plans, oversight of our progress and ongoing monitoring of impact and benefits.

Partnership working

We will work in partnership with other key organisations involved in the planning and provision of services to support population health and wellbeing. Examples of key partners include Fife Health and Social Care Partnership (HSCP), Fife Council, Fife Health Charity, Fife Voluntary Action, other NHS Boards and the Scottish Government.

We also have close relationships with local universities and colleges. They support both the delivery of education and training for our current and prospective workforce as well as innovation and research that benefits our current and future patients.

Continuing to involve our staff and the public

This strategy has been informed by extensive engagement with both staff and the public. Through ongoing engagement we will continue to respond and adapt to feedback enabling us to continually improve our services.

Programme planning and implementation

We will establish a range of strategic programmes to support the delivery of this strategy. Examples of NHS Fife programmes that currently underway include:

- **Integrated Unscheduled Care** – how we provide care in an emergency, including services provided by Minor Injuries Units, Emergency Department and Inpatient Care.
- **Integrated Planned Care** – care that is scheduled in advance, including outpatient appointments, diagnostics and inpatient/day-case treatment.
- **Cancer Services** – all services to support people with cancer, including diagnostics (such as scans), surgical services and non-surgical treatments such as chemotherapy.
- **High-Risk Pain Medicines** – improving patient safety through improved understanding, prescribing and access to alternatives to help people manage their pain conditions.
- **Digital and Information** – supporting the transformation of services using technology across Fife.
- **Financial Improvement and Sustainability** – ensuring the ongoing effective allocation of financial resources.

Our programmes will be developed in conjunction with our key partners. We will work together with the programmes of Fife Health and Social Care Partnership, such as Mental Health and Learning Disability programme to ensure our work remains joined up and delivers benefits to the population of Fife.

Communication

We will regularly report on the progress of implementation of the strategy to the staff and public. Clear and consistent disclosure of plans, progress, risks and opportunities will maintain trust and confidence that we are doing what we said we would.

Monitoring and evaluation

We will undertake ongoing monitoring and evaluation of the strategy. This will enable us to track our progress and achievements but also ensure we remain able to adapt to changing organisational priorities.

Published March 2023

The names of individuals in our patient stories have been changed for anonymity.

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Strategic Planning and Resource Allocation 2023/24 – Corporate Objectives 2023/24 Initial Proposal**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Bryan Archibald, Planning and Performance Manager**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance
- Discussion

This report relates to:

- Strategic Planning and Resource Allocation Process

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The Strategic Planning and Resource Allocation (SPRA) Process for 2023/24 is in progress.

The SPRA process is a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the 5-year

financial and strategic plan to support the delivery of the Population Health and Wellbeing Strategy. This paper provides an update on the process so far and outlines initial proposals for Corporate Objectives for 2023/24. Further work is ongoing to finalise the proposal with EDG.

2.2 Background

This is the third year of the Strategic Planning and Resource Allocation process which brings together the planning of services with financial and workforce implications of service delivery and change. It is an annual process which details how each directorate/programme supports the delivery of the overall organisational strategy.

2.3 Assessment

Workshops were held between 25th October and 11th November covering all Corporate and Acute Services Directorates. All five workshops were well attended with majority of SPRA templates returned by deadline (16th December). All templates were submitted by early January.

Templates have been reviewed and linked to Corporate Objectives for 2022/23 to propose revised Objectives for 2023/24. Further analysis of the templates will be required over the coming months to produce the Annual Delivery Plan (ADP) for 2023/24. Scottish Government have advised that guidance for ADP will be distributed by the end of February.

The below tables outline the proposed Corporate Objectives for 2023/24, aligned to Strategic Priorities. These detail whether the objective has been updated or is a direct carry over from 2022/23 objective or is a new addition following analysis of SPRA.

To Improve Health and Wellbeing		
Proposed 2023/24		**2022/23**
Implementation of the Population Health & Wellbeing Strategy through the development of detailed delivery plans	**UPDATED**	Develop the Population Health and Wellbeing Strategy
Develop the strategic plan to secure teaching Health Board Status with the University of St Andrews	**NO CHANGE**	Develop the strategic plan to secure teaching Health Board Status with the University of St Andrews

To Improve Health and Wellbeing		
Proposed 2023/24		**2022/23**
Develop and deliver the Fife COVID Recovery and Rehabilitation Framework	**NO CHANGE**	Develop and deliver the Fife COVID Recovery and Rehabilitation Framework
Deliver the OBC and progress to FBC for the Mental Health Services Programme	**UPDATED**	Deliver the Initial Agreement (IA) for the Mental Health Services Programme
Implement phase 1 of Mental Health Strategic Plan informed through collaborative working with people with lived experience and trauma informed practice	**UPDATED**	Refreshed Mental Health Strategic Plan informed through collaborative working with people with lived experience and trauma informed practice
Deliver the FBC and secure SG Funding Commitment for both the Kincardine and Lochgelly Health Centres	**UPDATED**	Deliver the OBC and progress to FBC for both the Kincardine and Lochgelly Health Centres
Implementation and delivery of Cancer Strategic Framework	***NEW***	
Delivery of the MAT Standards	***NEW***	

To Improve the Quality of Health and Care Services		
Proposed 2023/24		**2022/23**
Operationalise National Treatment Centre	**UPDATED**	Deliver the National Treatment Centre Fife and ensure operational readiness for opening
Implement a system wide medicines safety programme with initial focus on high-risk pain medicines	**UPDATED**	Develop and implement a system wide medicines safety programme with initial focus on high-risk pain medicines
Develop and deliver an enhanced model of care in the Emergency Department	**NO CHANGE**	Develop and deliver an enhanced model of care in the Emergency Department
Develop and deliver an augmented ambulatory, interface care model supporting early and appropriate discharge	**UPDATED**	Integrated Unscheduled Care Programme: Develop and deliver an augmented ambulatory, interface care model (RUC) supporting early and appropriate discharge
Develop Queen Margaret Hospital as an Ambulatory and Day Surgery Centre	**UPDATED**	Develop and implement an integrated planned care programme to address waiting list backlog, including the optimisation of day surgery at QMH

To Improve the Quality of Health and Care Services		
Proposed 2023/24		**2022/23**
Working in partnership to deliver Plan 4 Fife and evidence delivery of our Anchor ambitions	**UPDATED**	Oversight of NHS Fife Anchor Institution delivery plan for 2022/23
Deliver Home First to enable prevention of admission, person centred transfers of care and a responsive integrated system	**NO CHANGE**	Deliver Home First to enable prevention of admission, person centred transfers of care and a responsive integrated system
Deliver an approved Integrated Primary and Preventative Care Strategy to set the strategic direction supporting early intervention	**NO CHANGE**	Deliver an approved Integrated Primary and Preventative Care Strategy to set the strategic direction supporting early intervention
Develop and Implement the Women's Health Plan	***NEW***	
Deliver corporate and system leadership that contributes to system wide activities including Plan 4 Fife	**NO CHANGE**	Deliver corporate and system leadership that contributes to system wide activities including Plan 4 Fife

To Improve Staff Experience and Wellbeing		
Proposed 2023/24		**2022/23**
Deliver Safe Staffing and eRostering to support effective workforce planning to support high quality patient care alongside supporting staff health and wellbeing	**UPDATED**	Deliver high quality systems to support staff health and wellbeing
Create and Nurture a Culture of Person-Centred Care	***NEW***	
Evidence delivery of the strategic and career frameworks for NMAHP Bands 2 – 4	**UPDATED**	Develop and deliver strategic and career frameworks for NMAHP Bands 2 – 4
Evidence delivery of the Workforce Strategy	**UPDATED**	Develop the Workforce Strategy to support Population Health & Wellbeing Strateg
Increase the pace of delivery in the localities of Fife in line with the Plan for Fife.	**NO CHANGE**	Increase the pace of delivery in the localities of Fife in line with the Plan for Fife.
Develop and implement an NMAHP Care Assurance Framework	**NO CHANGE**	Develop and implement an NMAHP Care Assurance Framework
Develop and deliver the Faculty for Excellence in NMAHP education, training and professional development	**NO CHANGE**	Develop and deliver the Faculty for Excellence in NMAHP education, training and professional development

To Deliver Value and Sustainability		
Proposed 2023/24		**2022/23**
Commence delivery of the medium-term financial plan including the delivery of the Financial Improvement and Sustainability Programme	**UPDATED**	Develop and deliver the medium-term financial plan including the implementation of the Financial Improvement and Sustainability Programme
Implement the Climate Emergency and Sustainable Development Policy including agreed Net Zero commitments	**NO CHANGE**	Implement the Climate Emergency and Sustainable Development Policy including agreed Net Zero commitments
Develop the Initial agreement (IA) and Outline Business Case (OBC)	**UPDATED**	Develop the Initial agreement (IA) and Outline Business Case (OBC) for Robotics in Pharmacy
Delivery of New Laboratory Information system (LIMS) as part of accelerated implementation followed by implementation of national roll out.	***NEW***	

2.3.1 Quality/ Patient Care

The main aim of SPRA process is to continue to deliver high quality care to patients.

2.3.2 Workforce

Workforce planning is key to the SPRA process.

2.3.3 Financial

Financial planning is key to the SPRA process.

2.3.4 Risk Assessment/Management

Risk assessment is part of SPRA process and will be part in the prioritisation of key objectives.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

EDG – 16 February 2023

2.4 Recommendation

The Committee is asked to take **assurance** and **discuss** this initial proposal in relation to the Corporate Objectives for 2023/24.

3 List of appendices

None

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NHS Fife

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

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Information/Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Cancer Framework Delivery Plan update on 2022-23 actions is being presented to the Clinical Governance Committee (CGC) for information/assurance.

2.2 Background

The NHS Fife Cancer Framework has been developed to ensure that we can make a difference to how cancer services are delivered in Fife, ensuring it remains contemporary and reflects strategic changes both locally, regionally and nationally. An annual Delivery plan was created alongside the Cancer Framework for 2022-23.

2.3 Assessment

Assessment against the agreed priorities has been carried out.

40 objectives were identified as achievable by March 2023. 55% of these have been completed; 15.5% are in target and expected to be completed by March 23 and 27.5% have started or are partially complete with further actions identified which will be carried forward into 2023-24.

The table below provides an overview of the status of the objectives:

	No Objectives	Status			
		Complete	On Target	Not Started	C/F 2023-24
Commitment 1 A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives	7	4	1		2
Commitment 2 The patient will be at the heart of how services are designed	10	7	2		1
Commitment 3 Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal pathways and integrated care.	5		1		4
Commitment 4 Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.	3	2		1	
Commitment 5 Digitally enabled for sustainable and efficient service models which embrace technology and innovation	4	2			2
Commitment 6 Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care	7	6			1
Commitment 7 Ensure our healthcare environments are designed to deliver optimum patient care	3		1	1	1
Commitment 8 To make best use of available information sources to assure patients they are receiving high quality, effective care	1	1			
	40	22	5	2	11

There has been a great deal of work carried out over the last 12 months under challenging circumstances to achieve the objectives outlined; a brief update is provided on some of the successes and achievements below.

Commitment 1: Prevention, Early Diagnosis and Reduction in Inequalities

Health Promotion have supported training for adults to choose change rehabilitation and routinely promote awareness of access to resources. Their work included targeted campaigns through local community planning including priority groups with awareness of lifestyle risk factors aimed at the 16-24 year olds group. Work has been carried out on the Fife Physical Activity Strategy and food and health work upskilling knowledge on healthy eating behaviours. This work will be carried forward into 2023-24 along with further development to promote health campaigns such as Right Care Right Place.

HPV immunisation targets for S3 pupils in Fife schools were met with overall coverage of 86% (79% in SIMD1).

The Rapid Cancer Diagnosis Service (RCDS) won the Scottish Innovation Health Award and the principles RCDS have been successfully expanded into HPB and Upper GI tumour specific groups; this work will continue to expand into Colorectal in early March/April 23.

Commitment 2: Patient Centred

QR codes for Care Opinion are embedded in specific tumour sites to allow patient feedback. Patient representatives have been invited on to cancer groups.

The Single Point of Contact Hub was successfully launched in September 2022 for Colorectal and Urological cancers and is now expanding into Lung cancer.

Patients within Upper GI, Colorectal and Urology are now offered an Electronic Holistic Needs Assessment. Patient Initiated Review in Breast cancer services and a new Breast Pain Pathway has been introduced which has released capacity within the service to improve patient experience ensuring they are on the right pathway at the right time, with easy re-access if required.

A patient-facing cancer website has been developed to allow patients to access information about their disease.

A universal prehabilitation model has been introduced in Maggies Centre, Fife.

Commitment 3: Optimal Pathways and Integrated Care

Improvement of the Prostate pathway and implementation on an optimal Lung cancer pathway is underway to improve patient experience, earlier diagnosis and performance. A Pathway for Best Supportive Care is being developed; outputs of which will be shared nationally.

There has been significant improvement in the access to palliative care medicines in the community. Development of a ‘just in case box medicines’ policy is being reviewed as well as a dose-escalation palliative care Kardex, which are being taken forward in 2023-24.

Commitment 4: Research, Innovation and Knowledge

A breast oncology research nurse and PI for prostate cancer studies has been secured to ensure increased opportunities and equity of access to clinical trials.

Improvement in research, innovation and knowledge team involvement within the cancer governance structure is seen with routine sharing of innovative opportunities.

Commitment 5: Digital and Information

An electronic solution to support improve cancer tracking and data collection has been identified and work is ongoing to develop a business case to take forward.

The electronic Fife Referral Organisational Guidelines to support GPs with cancer referrals has been rolled out

Work is ongoing to provide patients with access to the Digital Patient Hub in the Rapid Cancer Diagnosis Service (RDCS).

Commitment 6: Workforce

A review of the SACT workforce has been undertaken and recurring funding secured to support a Specialist Doctor, Scheduler and administrative duties.

There has been a review of the MDT/Tracking resource and support continues to maintain the current model.

Pathway Navigators have been recruited across the organisation to support patients through their cancer journey. A complete training package has been developed by Macmillan for both Cancer Trackers and Patient Navigators.

Work is ongoing to take forward the national agenda to transform nursing roles and define training for Cancer Clinical Nurse Specialists.

Commitment 7: Property and Asset Management

Delivery of oral SACT outwith the SACT Day Unit is ongoing to release space and plans to repatriate SACT from Queen Margaret Hospital to Victoria Hospital are ongoing.

Commitment 8: Quality and Performance Improvement

The Effective Cancer Management Framework was launched in December 2021. An action plan was developed with excellent progress being made. An update on 2022-23 actions has been done and 2023-24 actions have been identified.

2.3.1 Quality / Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

Financial implications will be considered through the future Framework priorities.

2.3.4 Risk Assessment / Management

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

Engagement with leads to update the overview document.

2.3.8 Route to the Meeting

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

- Cancer Leadership Team (CLT) 21/02/2023

2.4 Recommendation

- **Information/Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Cancer Actions Overview Feb23
- Appendix No. 2, Cancer Annual Delivery Plan 2022-23

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

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	UPDATES CGC March 23	RAG Status	Actions/Comments to C/F to 2023-24
Commitment 1: A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives							
1.1 Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities.	1.1.1 Develop a system wide approach in collaboration with Health Promotion to focus on promoting holistic assessments of patient's risk for the cancers which are attributable to life style across hard to reach groups e.g., Making every contact count	Agree plan to increase uptake of education, resources and support	2022-23	Health Promotion Manager	Health Promotion Service contribution - Provision of training- Good Conversations, helping adults to choose change rehabilitation videos - reduce or stop drinking and smoking prior to hospital admissions to reduce risk during hospital stay and surgery complications.	Complete	
	1.1.2 Promote good community orientation through improving awareness	Plan to increase awareness and availability of Health Promotion resources through staff training of awareness to support community orientation.	Mar-23	Health Promotion Manager	Health Promotion Service contribution through routine awareness of access to the system of resources available including signposting and links to services and support locally and nationally Health Promotion resources including IRC, training, targeted campaigns and health topics etc are promoted regularly through local community planning and partnership groups. forums and with priority groups. For example, input to Fife College to raise awareness of lifestyle risk factors of cancer with 16-24 year olds (alcohol, food and health and addictive behaviours). Work is also underway to test approaches to promote health topic information and key campaigns such as Right Care Right Place in local community settings working, and this will be developed during 2023.	2023-24	Work is underway to test approaches to promote health topic information and key campaigns such as Right Care Right Place in local community settings working, and this will be developed during 2023.
	1.1.3 Support the public, patients and staff to eat well, have a healthy weight and be physically active	Development of Action Plan to review data for the NHS National Physical Activity Pathway	2022-23	Health Promotion Manager	There have been several meetings of key partners progressing the actions in Fife Physical Activity Strategy. Food and Health work has been progressed and a number of programmes. For example, provision of training to upskill knowledge and understanding of healthy eating behaviours and build capacity within community (Food Champion training). Provision of training to raise awareness of impact of healthy eating and exercise and link to cancer to increase knowledge and understanding and build capacity within Early Years staff (HENRY). Due to reduced capacity the Physical Health Activity has not progressed as intended. Work being progressed to establish a short life working group to review pathway and data capture.	2023-24	Due to reduced capacity the Physical Health Activity has not progressed as intended. Work being progressed to establish a short life working group to review pathway and data capture.
1.2 Protect people from cancer through HPV vaccination, maintaining immunisation coverage rates and reducing inequalities in coverage	1.2.1 Achieve HPV immunisation coverage of 85% for females by end of S3 across SIMD.	85% of females in S3 will be immunised against HPV	2022-23	Consultant, Public Health (Esther)	HPV programme has changed from 2 dose to 1 dose schedule , therefore dose 1 now indicates completed course / fully vaccinated (https://www.sehd.scot.nhs.uk/cmo/CMO(2022)35.pdf)	Complete	

					HPV dose 1 immuinsation coverage rates for S3 in Fife schools for 2021/22 academic year met overall 85% target (89% females; males 83%; both sexes 86%). SIMD data provided for both sexes only: SIMD 1 (most deprived) uptake =79%; SIMD 5 (least deprived) uptake = 93%. End S4 SIMD 1 uptake = 91%; SIMD 5 = 93%. Propose revise the outcome target for 2022/23 school year (reporting in 2023/24) in line with WHO cervical cancer elimination goal for 90% females vaccinated by age 15: - Proposed wording for description: Sustain and improve HPV dose 1 coverage rates across Fife for both sexes. - Proposed wording for outcome: Achieve HPV dose 1 immmunisation coverage of 90% for females by end of S4 in Fife. Achieve 85% uptake by end S4 across all SIMD quintiles for both sexes by end S4.		
1.3 Review the impact of the Fife Early Cancer Diagnosis Centre with a view to expanding to other specific tumour sites.	1.3.1 Explore expansion of RCDS principles to other Urgent Suspicion of Cancer (USOC) pathways.	Defining an agreed proposal and implementation plan to expand the principles of RCDS through engagement and collaboration with Acute Services Division	Mar-23	Lead Cancer Nurse (Murdina)	Expansion of the principles of RCDS TOC within UGI and HPB - live in January 2023 Working on ARCT Interviewing for addiitonal RCDS nurse Expanding to Colorectal 2023-24	Complete	
	1.3.2 Scope potential for Community Pharmacy USOC referral involvement.	Earlier access to a USC pathway via direct referral to Secondary Care	Mar-23	Lead Cancer GP (Nick)	Proposal presented at the CGSG 13/01/23. Take proposal forward 2023-24	Complete	
	1.3.3 Scope and understand population profile referred to Rapid Cancer Diagnostic Service (RCDS) (formerly known as Early Cancer Diagnosis Centre (ECDC))	Use data as a baseline to inform any further primary care or public health interventions	Mar-23	Consultant, Public Health (Rishma)	Lead Cancer Nurse analysing data between June 21-Dec 21 to identify if any patients who were referred to RCDS have subsequently gone on to develop a cancer. Have identified the headers required. Requested a report to be created- expected mid january	On target	
Commitment 2: The patient will be at the heart of how services are designed.							
2.1 Actively include the views and experiences of patients and carers through continued engagement.	2.1.1 Widely introduce Care Opinion across the cancer services to ensure patient feedback is incorporated into quality and safety improvement	Improvement in Care Opinion feedback from cancer patients	Mar-23	Lead Cancer Nurse (Murdina)	Services now have QR codes for specific cancer sites. CNSs are Care Opinion owners. Specifically able to differenticate between HPB and UGI coming through RCDS. Good data from Care Opinion	Complete	
	2.1.2 Cancer patients will be represented at cancer groups with a review undertaken to ensure appropriate representation and involvement	Successful appointment of patient representation at Cancer Groups	01/06/2022 Complete	Lead Cancer Nurse (Murdina)	Patient representatives invited on to cancer groups. To continue patient engagement through the Cancer Framework and Delivery Plan	Complete	
2.2 Services will be designed to ensure there is a dedicated Single Point of Contact to provide information points for appointments, advice, clinical and other support	2.2.1 Introduce a Single Point of Contact and Patient Digital Hub.	Make service available to agreed pilot tumour groups	01/09/2022 Complete	Cancer Transformation Manager (Kathy)	Service introduced 1/9/22. Successfully implemented for all patients referred urgent suspected and diagnosed with colorectal or urological cancers. Expanding into lung 2023-24	Complete	
	2.2.2 Evaluation of new service	Assessment of evaluation will inform improvement actions	31/03/2023	Cancer Transformation Manager (Kathy)	6 month evaluation will commence February 2023. Patient questionnaire has been created. Baseline data has been received. To do a Staff patient questionnaire (GP and CNSs)	On target	

2.3 Improve sharing of quality information with patients and primary care via electronic Holistic Needs Assessment (eHNA) and treatment summaries.	2.3.1 Scope baseline of use of electronic Health Needs Assessment (eHNA) and improve the usage in Cancer Care through Cancer Nurse Specialist (CNS) training	90% of new patients within Upper GI, Colorectal, and Urology cancer will be offered an eHNA	2022-23	Lead Cancer Nurse (Murdina)	Awaiting eHNA Service Level Agreement between HCSP and NHS Baseline for 2022. Target of increasing the offer to be carried forward into 2023-24	2023-24	
	2.3.2 Introduction of Patient Initiated Review (PIR) in Breast Service	Release capacity in the breast service and allow patients direct access to services	2022-23	Lead Cancer Clinician (John)	PIR introduced in the breast service, releasing capacity to see more new patients (referrals have significantly increased). Routes back into service should patients see changes. In line with other Boards. Patients still receive annual mammo.	Complete	
	2.3.4 Explore clinical dashboard metrics for CNS to scope and understand measures already in use	Identify metrics for a clinical dashboard for CNSs	Mar-23	Lead Cancer Nurse (Murdina)	Urology has been identified a test site for CNS clinical dashboard	Complete	
2.4 Develop a Cancer Services website Dedicated to helping people who face cancer learn about patient services	2.4.1 Develop a Cancer Services website for the public to ensure access to information on specific cancer sites and learn about local, regional and National cancer Information	Electronic access to information for patients	2022-23	Lead Cancer Nurse (Murdina)	Cancer patient webiste introduced: https://www.nhsfife.org/cancer/	Complete	
	2.4.2 Develop a virtual surgery school for patients with urology and colorectal cancer	To support Urology and Colorectal patients undergoing surgery and evaluate using monthly Performance Activity Measures (PAMs)	2022-23	Lead Cancer Nurse (Murdina)	1/2 dozen podcasts in place	On target	
2.5 Ensure patients have access to prehabilitation and rehabilitation for optimum fitness prior and post treatment	2.5.1 Delivery of a universal prehabilitation model in Maggies Centre, Fife for urology and colorectal cancer patients, building on the test of change to expand to all cancers	Activity by attendee Cancer type Activity by month Performance Activity Measures (PAM)	Mar-23	Lead Cancer Nurse (Murdina)	Up to end of September 2022 195 patients attended universal Prehabilitation. 77%of patients self report improvements This is being expanded into all cancer types.	Complete	
Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal pathways and integrated care.							
3.1 Implement optimal pathways and prioritised review of timed cancer pathways	3.1.1 Prioritised review of optimal and timed cancer pathways (Colorectal, Lung, Gynaecology, Urology).	Improvement in delivery of cancer waiting times standards for prioritised pathways	Mar-23	Cancer Transformation Manager (Kathy)	Identified prostate and lung as prioritised pathways for review Prostate Project Group set up. To look at a nurse-led pathway to MDT - CRUK TET funding secured to support review. Optimal Lung Pathway funding for 2022-23. Scoping current resource and expected requirements. To carry forward beyond March 2023	2023-24	Project groups set up to take forward. Expect to land in 2023-24
3.2 Embed a new model of specialist palliative care, optimise on generalist palliative care and develop a best supportive care pathway.	3.2.1 Specialist Palliative Care and Primary Care will collaborate to model a best supportive care (BSC) pathway for Fife	Development of a Framework contributing towards the national agenda	Mar-23	Lead Cancer GP (Nick)	Ongoing work. NEF Cluster showed no interest in QI work. Awaiting further info on funding opportunities from Helen Hellewell. Considering engagement with regional Primary Care Palliative Care leads to propose and agree standards. Pilot ongoing to use standardised template to communicate between Lung CNS team and Primary care. Jo Bowden and I have been invited to present Fife BSC developments at British Gynaecological Cancer Society conference and to NHS Grampian cancer conference.	2023-24	
		Develop a pathway for BSC for lung cancer	Mar-23	Lead Cancer GP (Nick/Murdina)	Best supportive care leaflet being developed. All CNS will be expected to roll out the same documentation. Working closely with colleagues in Lothian Pathways will be further developed in 2023-2	2023-24	

	3.2.3 Develop models of prescribing and supply of palliative care medicines		Mar-23	Lead Pharmacist for Community Health	**Access to palliative care medicines in the community** The palliative care community pharmacy agreed stocklist has been reviewed and updated to reflect the demand for the palliative care medicines in the Community. The palliative care out reach team have a HBP prescription pad to access palliative care medicines for community patients via the Community Pharmacy **Palliative care medicine expenditure 2021-22** This was reviewed in August 2022 and there were no concerns. COMPLETE **Just in case box medicines** The NHS Fife just in case box policy is currently being reviewed and it is anticipated that the new version of the policy will be launched in Summer/Autumn 2023. C/F FURTHER ACTIONS TO 2023-24 **Palliative care medicines prescribing** The NHS Fife Palliative Care Pharmacist is developing a dose-escalation palliative care kardex which is currently being reviewed and going through the approval process. C/F FURTHER ACTIONS TO 2023-24	2023-24	Just in case box medicines The NHS Fife just in case box policy is currently being reviewed and it is anticipated that the new version of the policy will be launched in Summer/Autumn 2023. Palliative care medicines prescribing The NHS Fife Palliative Care Pharmacist is developing a dose-escalation palliative care kardex which is currently being reviewed and going through the approval process.
3.3 Develop a SACT model that ensures timely access to treatment and optimal treatment delivered in the most appropriate setting	3.3.1 Develop a plan for repatriation of SACT to VHK	Development of a plan to support repatriation	Mar-23	Associate Director of Quality & Clinical Governance (Shirley Anne)	Part of the work of the Ambulatory SLWG to repatriate SACT from QMH to VHK. Space identified at VHK. Discussion ongoing regarding refurbishment. UPDATE	On target	
Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.							
4.1 Explore a Hub and Spoke model of care to ensure equitable access to clinical trials, closer to home.	4.1.1 Seek suitable Clinical Trial of Investigational Medicinal Product CTIMPS with regional partners (Lothian, Tayside) to trial hub and spoke and other models.	To increase research opportunities and equity of access to clinical trials for cancer patients in Fife – New Breast Cancer Research Nurse appointed	Sep-23	Associate Director, RIK (Frances Quirk)	Recruitment of breast oncology research nurse. Consultant interest in acting as PI for prostate cancer studies. Continue to seek opportunities within the cancer enviroment.	Complete	
	4.1.2 Consider legal requirements for supply of clinical trial medicines.	Compliance with all legal requirements including temp controlled storage and transport between hub and spoke sites if required.	TBC	TBC	KN to check - emailed ST 5/1 emailed ST 14/02	No update	
4.2 Improve links with East Region Innovation Hub.	4.2.1 Share cancer related innovation opportunities and liaise with relevant clinicians, academics, industry	Increase Research Innovation and Knowledge (RIK) cancer opportunities	Mar-23	Associate Director, RIK (Frances Quirk)	Opportunities identified. To take forward in the New Year NHS Fife has been approached to join regional partners in Health Innovation South East Scotland (HISES) to collaborate on a regional bid for Scotland's optimal lung cancer diagnostic pathways, addressing the deficiencies at the diagnostic end of the pathway. This is a £3M fund from the Scottish Government. Innovation Manager forwarded the call onto relevant colleagues in NHS Fife for awareness.	Complete	

Commitment 5: Digitally enabled for sustainable and efficient service models which embrace technology and innovation							
5.1 Develop cancer clinical information systems	5.1.1 Explore robust tracking solution to support effective and efficient patient tracking.	Develop business case for change and implementation of project team	Mar-23	Cancer Transformation Manager (Kathy)	MORSE identified as a potential solution. Prototype developed. Service Workpackage completed for AST. Quote to be sought from CAMBRIC followed by development of a business case. Wider exploration of a shared solution across SCAN - not feasible. C/F 2023-24	2023-24	Quote and business case required.
5.2 Support the improvement of the cancer referral process	5.2.1 Introduce Fife Referral Organisational Guidelines (FROG)	Electronic access for GPs to optimum referral suspected cancer referral guidance	Oct-22	Lead Cancer Nurse (Murdina)	On track. Out to lead clinicians for comment. Positive reponses to date. This is now live: https://app.joinblink.com/#/hub/46c35009-f9d3-45cd-b0fd-a1a0f006f701	Complete	
	5.2.2 Introduce patient access to information and patient initiated review	Introduction of PIR into breast service	Oct-22	Lead Cancer Clinician (John)	PIR introduced in the breast service, releasing capacity to see more new patients (referrals have significantly increased). Routes back into service should patients see changes. In line with other Boards. Patients still receive annual mammo.	Complete	
5.4 Support change in availability of digital enablement to support patients	5.4.1 Develop a Digital Patient Hub in RCDS	Patient electronic access to appointments and information	Mar-23	Lead Cancer Nurse (Murdina)	Patient Digital Hub under development for RCDS as this service does not overbook. Due to the nature of the service, patients will not be able to cancel in the App and will be required to telephone. Expect go live January 23 Technical issues have resulted in this action being carried forward into 2023-24	2023-24	
Commitment 6. Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care							
6.1 Review the cancer workforce including skill mix and supporting roles to inform future service delivery models and succession planning.	6.1.1 Undertake AO/SACT (including clinical and technical pharmacy) workforce review.	Continue to define workforce required to deliver AO and SACT to meet current and future demand	Mar-23	Cancer Transformation Manager (Kathy)	Confirmed recurring funding of £103k. Focussing on SACT in the first instance. SCAN to invoice then send recurringly thereafter. Specialty Doctor, Scheduler and admin support (TBC).	Complete	
	6.1.2 Review MDT and Tracking resource	Understanding of resource required. Use of number of MDT and patients tracked.	Dec-22	Cancer Transformation Manager (Kathy)	13/12/22 - submitted to SAS for onward discussion with CMcK - await outcome. Posts secured non-recurringly beynd April 2023 and under review	Complete	
	6.1.3 Undertake urology cancer nursing workforce review	Completion of a skill set for Patient Navigators matrix	Mar-23	Lead Cancer Nurse (Murdina)	Macmillan Skills Matrix rolled out to all PNs in both Services and SPOCH	Complete	
	6.1.5 Support staff retention and wellbeing through Values Based Reflective Practice (VBRP)	Availability of VRBP for all Cancer Clinical Nurse Specialists and Patient Navigators	Mar-23	Lead Cancer Nurse (Murdina)	Open to CNS and PNs. Funding only available until March 23.	Complete	
	6.1.6 Explore funding for the continuation of VBRP	Evaluation exercise to understand required resources (funding)	Mar-23	Lead Cancer Nurse (Murdina)	Utilised for 2022-23. No funding available beyond March 23	Complete	
6.2 Work towards the national agenda to transform roles with consideration of Senior Professional Leadership/Management of CNS/ANP/AHP workforce.	6.2.1 Promote early engagement with local transforming nursing roles programme	Achievement of objectives outlined for 2022-23 by the national group.	2022-23	Lead Cancer Nurse (Murdina)	Awaiting recruitment within the nursing directorate To carry forward into 2023-24	2023-24	
	6.2.2 Scope and assess existing competency and role parameters for CNSs within cancer services	Define Annex 21 training for Cancer CNSs to align with the national guidelines.	2022-23	Lead Cancer Nurse (Murdina)		Complete	
Commitment 7. Ensure our healthcare environments are designed to deliver optimum patient care							

7.1 Review the estate across NHS Fife to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future.	7.1.1 Establish a working group to develop the concept of a cancer unit in NHS Fife	Define concept of cancer unit, unmet need in NHS Fife to inform development of a case for a unit	Mar-23	Associate Director, Quality and Clinical Governance (Shirley Anne)	Links in with Ambulatory work. Identified locations, to progress, C/F take forward 2023-24 - still need to review. Need to understand the Oncology Workforce Review, outcome of IA, etc.	2023-24	Repatriate SACT unit from QMH to VHK
7.2 Explore community based models of care, e.g. community dispensing, supportive therapies.	7.2.1 Explore Community and Homecare Dispensing of oral SACT.	Commence prescribing of Prostate Oral SACT	Jan-23	Associate Director, Quality and Clinical Governance (Shirley Anne)	A member of staff who is training at present with the prostate oncologists with a view to commencing prescribing clinic for oral prostate SACT. UPDATE	On target	
	7.2.2 Review delivery of Non SACT Interventions.		Mar-23		Shirley Anne to update May not be community based but other areas in acute services UPDATE	Not started??	
Commitment 8: To make best use of available information sources to assure patients they are receiving high quality, effective care							
8.1 Embed the Effective Cancer Management Framework into the cancer team's workplan, supported by senior management to ensure full adoption.	8.1.1 Implement the principles of the effective cancer management framework to manage patients through their pathways.	Achieve objectives outlined for 2022/23 in the action plan	Mar-23	Cancer Transformation Manager (Kathy)	Action plan completed and agreed. Monthly update provided to SG Frequency changed to quarterly. Update for 2022-23 complete. Identified actions for 2023-24	Complete	

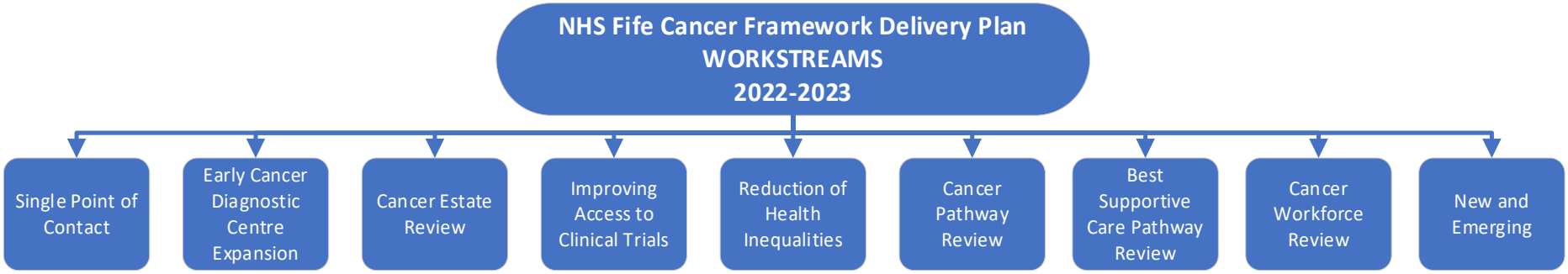
	No Objectives	Status				
		Complete	On Target	Not Started	C/F 2023-24	
Commitment 1 A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives	**7**	4	1		2	7
Commitment 2 The patient will be at the heart of how services are designed	**10**	7	2		1	10
Commitment 3 Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal pathways and integrated care.	**5**		1		4	5
Commitment 4 Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.	**3**	2		1		3
Commitment 5 Digitally enabled for sustainable and efficient service models which embrace technology and innovation	**4**	2			2	4
Commitment 6 Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care	**7**	6			1	7
Commitment 7 Ensure our healthcare environments are designed to deliver optimum patient care	**3**		1	1	1	3
Commitment 8 To make best use of available information sources to assure patients they are receiving high quality, effective care	**1**	1				1
	40	**22**	**5**	**2**	**11**	

Cancer Framework Delivery Plan Year 1

2022–2023

Cancer framework delivery plan year 1 (2022–2023)

The aspiration of this framework will only be fully realised with a clear and focused annual delivery plan with key workstreams for 2022–2023. This Framework will be reviewed on a monthly basis by the Cancer Leadership Team given the changing nature of our healthcare systems.



Need to build in timescales and plan for review of framework and approach for identification of new priorities for 23/24

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
Commitment 1: A focus to reduce cancer incidence, mortality and inequalities for our patients through effective prevention, screening and early detection initiatives							
1.1 Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities.	1.1.1 Develop a system wide approach in collaboration with Health Promotion to focus on promoting holistic assessments of patient's risk for the cancers which are attributable to life style across hard to reach groups e.g., Making every contact count 1.1.2 Promote good community orientation through improving awareness	Agree plan to increase uptake of education, resources and support Plan to increase awareness and availability of Health Promotion resources through staff training of awareness to support community orientation.	2022-23 March 2023	Consultant, Public Health Health Promotion Nurse Manager	Lead Cancer GP Lead Cancer GP Consultant, Public Health	Health Promotion Nurse Manager	Health Improvement Scotland (HIS) Communications Health Improvement Scotland (HIS) Communications

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	1.1.3 Support the public, patients and staff to eat well, have a healthy weight and be physically active	Development of Action Plan to review data for the NHS National Physical Activity Pathway	2022-23	Health Promotion Nurse Manager	Consultant, Public Health	NHS/H&SCP Delivery Group	AHP Implementation Group
1.2 Protect people from cancer through HPV vaccination, maintaining immunisation coverage rates and reducing inequalities in coverage	1.2.1 Achieve HPV immunisation coverage of 85% for females by end of S3 across SIMD.	85% of females in S3 will be immunised against HPV	2022-23	Immunisation Coordinator	Immunisation Programme Director, H&SCP Associate Medical Director, H&SCP Associate Nurse Director Lead Pharmacist Head of Strategic Planning & Performance		Screening Coordinator
1.3 Review the impact of the Fife Early Cancer Diagnosis Centre with a view to expanding to other specific tumour sites.	1.3.1 Explore expansion of RCDS principles to other Urgent Suspicion of Cancer (USOC) pathways.	Defining an agreed proposal and implementation plan to expand the principles of RCDS through engagement and collaboration with Acute Services Division	March 2023	Lead Cancer Nurse	Lead GP RCDS Lead Cancer GP General Manager Cancer Transformation Manager	Project Support Officer Consultant Surgeon Clinical Director Lead Cancer Clinician	ACNS RCDS Consultant Surgeons, UGI Respiratory Physician Respiratory CNSs UGI CNSs
	1.3.2 Scope potential for Community Pharmacy USOC referral involvement.	Earlier access to a USC pathway via direct referral to Secondary Care		Lead Cancer GP	Community Pharmacy Head of Pharmacy Radiology Clinical Service Leads	Cancer Transformation Manager Project Support Officer	Director of Pharmacy

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	1.3.3 Scope and understand population profile referred to Rapid Cancer Diagnostic Service (RCDS) (formerly known as Early Cancer Diagnosis Centre (ECDC))	Use data as a baseline to inform any further primary care or public health interventions	March 2023	Consultant, Public Health	Lead Cancer GP Lead Cancer Nurse	Project Support Officer	
Commitment 2: The patient will be at the heart of how services are designed.							
2.1 Actively include the views and experiences of patients and carers through continued engagement.	2.1.1 Widely introduce Care Opinion across the cancer services to ensure patient feedback is incorporated into quality and safety improvement	Improvement in Care Opinion feedback from cancer patients	March 2023	Lead Cancer Nurse	Head of Patient Experience	ACNS RCDS Cancer Transformation Manager Clinical Nurse Managers	Health Improvement Scotland ACNS Urology ACNS RCDS CNS UGI CNS Colorectal CNS Breast CNS Gynaecology Nurse Consultant, Haematology Acute Oncology Nurse Practitioner
	2.1.2 Cancer patients will be represented at cancer groups with a review undertaken to ensure appropriate representation and involvement	Successful appointment of patient representation at Cancer Groups	01/06/2022 Complete	Lead Cancer Nurse	Head of Patient Experience	Cancer Transformation Manager Project Support Officer	

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
2.2 Services will be designed to ensure there is a dedicated Single Point of Contact to provide information points for appointments, advice, clinical and other support	2.2.1 Introduce a Single Point of Contact and Patient Digital Hub. 2.2.2 Evaluation of new service	Make service available to agreed pilot tumour groups Assessment of evaluation will inform improvement actions	01/09/2022 Complete 31/03/2023	Cancer Transformation Manager Cancer Transformation Manager	Lead Cancer Nurse Cancer Audit & Performance Manager Lead Cancer Nurse Cancer Audit & Performance Manager	SPOCH Project Group	National SPOC Forum
2.3 Improve sharing of quality information with patients and primary care via electronic Holistic Needs Assessment (eHNA) and treatment summaries.	2.3.1 Scope baseline of use of electronic Health Needs Assessment (eHNA) and improve the usage in Cancer Care through Cancer Nurse Specialist (CNS) training 2.3.2 Introduction of Patient Initiated Review (PIR) in Breast Service 2.3.4 Explore clinical dashboard metrics for CNS to scope and understand measures already in use	90% of new patients within Upper GI, Colorectal, and Urology cancer will be offered an eHNA Release capacity in the breast service and allow patients direct access to services Identify metrics for a clinical dashboard for CNSs	2022-23 2022-23 March 23	Lead Cancer Nurse Lead Cancer Clinician Lead Cancer Nurse	CNSs in cancer care Information Governance Macmillan Improving Cancer Journey (ICJ) Consultant Surgeon, Breast ACNS Breast Senior Practitioner, PPD Senior Nurse, Excellence in Care	CNS UGI ACNS Urology CNS Urology CNSs Colorectal Business Coordinator, Planned Care CNSs in cancer care	Pathway Navigators eHealth Clinical Governance

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
2.4 Develop a Cancer Services website Dedicated to helping people who face cancer learn about patient services	2.4.1 Develop a Cancer Services website for the public to ensure access to information on specific cancer sites and learn about local, regional and National cancer Information	Electronic access to information for patients	2022-23	Lead Cancer Nurse	Digital Content Editor GPs ACNS Cancer CNSs Consultant Surgeon, Breast, Urology, UGI, HPB Respiratory Physician Cancer Transformation Manager	Project Support Officer Lead Cancer GP	Patients National Charities Local Charities National organisations
	2.4.2 Develop a virtual surgery school for patients with urology and colorectal cancer	To support Urology and Colorectal patients undergoing surgery and evaluate using monthly Performance Activity Measures (PAMs)	2022-23	Lead Cancer Nurse	Clinical Photography Communications	Consultant Anaesthetists Lead Nurse, RIK ACNS Urology ERAS Nurse Mental Health Nurse Epilepsy Nurse Physiotherapy Manager Senior Charge Nurse Stop Smoking Coord	Service Manager, Planned Care Head of Nursing, Planned Care
2.5 Ensure patients have access to prehabilitation and rehabilitation for optimum fitness prior and post treatment	2.5.1 Delivery of a universal prehabilitation model in Maggies Centre, Fife for urology and colorectal cancer patients, building on the test of change to expand to all cancers	Activity by attendee Cancer type Activity by month Performance Activity Measures (PAM)	March 23	Lead Cancer Nurse	Maggies Centre Manger	Cancer nurse Specialists AHP	Planned Care Directorate Acute Cancer Services Delivery Group Cancer Governance and Cancer Strategy group

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal pathways and integrated care.							
3.1 Implement optimal pathways and prioritised review of timed cancer pathways	3.1.1 Prioritised review of optimal and timed cancer pathways (Colorectal, Lung, Gynaecology, Urology).	Improvement in delivery of cancer waiting times standards for prioritised pathways	March 23	Cancer Transformation Manager	Lead Cancer Nurse Lead Cancer Clinician Service Manager, WCCS	Colorectal Team Urology Team Lung Team Gynaecology Team	Trackers Clinical Leads
3.2 Embed a new model of specialist palliative care, optimise on generalist palliative care and develop a best supportive care pathway.	3.2.1 Specialist Palliative Care and Primary Care will collaborate to model a best supportive care (BSC) pathway for Fife 3.2.3 Develop models of prescribing and supply of palliative care medicines	Development of a Framework contributing towards the national agenda Develop a pathway for BSC for lung cancer	March 23 March 23 March 23	Lead Cancer GP Lead Cancer GP TBC	Consultant, Palliative Care Consultant, Palliative Care Lead Clinical Pharmacist, Community	CNSs Lung	Lead Cancer Nurse Cancer Transformation Manager
3.3 Develop a SACT model that ensures timely access to treatment and optimal treatment delivered in the most appropriate setting	3.3.1 Develop a plan for repatriation of SACT to VHK	Development of a plan to support repatriation	March 23	Cancer Transformation Manager	Lead Cancer Nurse Nurse Consultant, Haematology Principal Pharmacist, Cancer Heads of Pharmacy Capital & Estates		
Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.							

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
4.1 Explore a Hub and Spoke model of care to ensure equitable access to clinical trials, closer to home.	4.1.1 Seek suitable Clinical Trial of Investigational Medicinal Product CTIMPS with regional partners (Lothian, Tayside) to trial hub and spoke and other models. 4.1.2 Consider legal requirements for supply of clinical trial medicines.	To increase research opportunities and equity of access to clinical trials for cancer patients in Fife – New Breast Cancer Research Nurse appointed Compliance with all legal requirements including temp controlled storage and transport between hub and spoke sites if required.	September 23 Update	Associate Director, RIK TBC	Clinical Research Team Oncology and Medicine Lead Lead Nurse, RIK Sally Tyson Senior Pharmacist-Clinical Trials	South East Scotland Clinical Research Network (SESCRN) Clinical research team Oncology Consultants Medicines Supply Chain Manger Specialist Pharmacy Technician-Dispensary	NHS Research Scotland Chief Scientist Office SESCRN Lead Nurse, RIK
4.2 Improve links with East Region Innovation Hub.	4.2.1 Share cancer related innovation opportunities and liaise with relevant clinicians, academics, industry	Increase Research Innovation and Knowledge (RIK) cancer opportunities	March23	Innovation Manager	Associate Director, RIK Innovation Manager HISES Project Management team	HISES Innovation Project Screening Group NHS Fife Innovation Project Screening Group NHS Fife D&I	HISES Innovation Oversight Committee (IOC) RIK Operational Group RIK Oversight Group
Commitment 5: Commitment: Digitally enabled for sustainable and efficient service models which embrace technology and innovation							
5.1 Develop cancer clinical information systems	5.1.1 Explore robust tracking solution to support effective and efficient patient tracking.	Develop business case for change and implementation of project team	March 23	Cancer Transformation Manager	Cancer Audit & Performance Manager Senior Project Manager eHealth Team CAMBRIC	Trackers	SCAN

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
5.2 Support the improvement of the cancer referral process .	5.2.1 Introduce Fife Referral Organisational Guidelines (FROG) 5.2.2 Introduce patient access to information and patient initiated review	Electronic access for GPs to optimum referral suspected cancer referral guidance Introduction of PIR into breast service	October 22 October 22	Lead Cancer Nurse Lead Cancer Clinician	Project Support Officer Cancer Transformation Manager Consultant Surgeon, Breast	Lead Cancer GP Business Coordinator, Breast Cancer Transformation Manager	
5.4 Support change in availability of digital enablement to support patients	5.4.1 Develop a Digital Patient Hub in RCDS	Patient electronic access to appointments and information	March 23	Cancer Transformation Manager (KN holds budget for this???)	Lorna Thomson Lead Cancer Nurse Project Support Officer Cancer Transformation Manager Katie Wilkin	Lorna Muir Trish Cochrane	
Commitment 6. Recognise workforce challenges and identify system-wide approaches to support wellbeing, education and training to ensure our patients receive the best care							
6.1 Review the cancer workforce including skill mix and supporting roles to inform future service delivery models and succession planning.	6.1.1 Undertake AO/SACT (including clinical and technical pharmacy) workforce review. 6.1.2 Review MDT and Tracking resource	Continue to define workforce required to deliver AO and SACT to meet current and future demand Understanding of resource required. Use of number of MDT and patients tracked.	March 23 December 22	Cancer Transformation Manager Shirley-Anne Savage Cancer Transformation Manager	Claire Steele John Brown Nurse Consultant, Haematology Principal Pharmacist Oncologist Cancer Audit & Performance Manager	Acute Oncology Nurse Practitioners Trackers	

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
	6.1.3 Undertake urology cancer nursing workforce review	Completion of a skill set for Patient Navigators matrix	March 23	Lead Cancer Nurse	Heads of Nursing Senior Practitioner, PPD Senior Nurse, Excellence in Care	ACNS, Urology	Associate Director of Head of Nursing Head of Nursing
	6.1.5 Support staff retention and wellbeing through Values Based Reflective Practice (VBRP) 6.1.6 Explore funding for the continuation of VBRP	Availability of VRBP for all Cancer Clinical Nurse Specialists and Patient Navigators Evaluation exercise to understand required resources	March 23 March 23	Lead Cancer Nurse Lead Cancer Nurse	Spiritual and Pastoral Care Spiritual and Pastoral Care Senior Leadership Team		All Cancer CNSs All Cancer Patient Navigators
6.2 Work towards the national agenda to transform roles with consideration of Senior Professional Leadership/Management of CNS/ANP/AHP workforce.	6.2.1 Promote early engagement with local transforming nursing roles programme 6.2.2 Scope and assess existing competency and role parameters for CNSs within cancer services	Achievement of objectives outlined for 2022-23 by the national group. Define Annex 21 training for Cancer CNSs to align with the national guidelines.	2022-23 2022-23	Lead Cancer Nurse Lead Cancer Nurse	Senior Nurse, PPD Executive Group TNR Senior Nurse PPD Executive Group TNR	Heads of Nursing Heads of Nursing	Cancer CNSs CNS in other specialties Cancer CNSs

Priority for 2022–2023	Description	Outcome (including measures)	Timescale	Leading (L) Responsible for Delivery	Critical (C) Critical for Delivery	Active Contributor (AC) Actively Engaged	Supporter (S) Inform and Support
Commitment 7. Ensure our healthcare environments are designed to deliver optimum patient care							
7.1 Review the estate across NHS Fife to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future.	7.1.1 Establish a working group to develop the concept of a cancer unit in NHS Fife	Define concept of cancer unit, unmet need in NHS Fife to inform development of a case for a unit	March 23	Cancer Transformation Manager	TBC	TBC	TBC
7.2 Explore community based models of care, e.g. community dispensing, supportive therapies.	7.2.1 Explore Community and Homecare Dispensing of oral SACT. 7.2.2 Review delivery of Non SACT Interventions.	Commence prescribing of Prostate Oral SACT	January 23	Cancer Transformation Manager	Principal Pharmacist Head of Pharmacy Head of Pharmacy, Governance & Therapeutics		
Commitment 8: To make best use of available information sources to assure patients they are receiving high quality, effective care							
8.1 Embed the Effective Cancer Management Framework into the cancer team's workplan, supported by senior management to ensure full adoption.	8.1.1 Implement the principles of the effective cancer management framework to manage patients through their pathways.	Achieve objectives outlined for 2022/23 in the action plan	March 23	Cancer Transformation Manager	Cancer Audit & Performance Manager Lead Cancer GP	Cancer Audit & Performance Team	Acute Services

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan

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 generally up to the end of December 2022, although there are some measures with a significant time lag and a few which are available up to the end of January.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board and is produced monthly.

Improvement actions are included following finalisation of the Annual Delivery Plan for 2022/23 and this streamlines local reporting for governance purposes with quarterly national reporting to the Scottish Government.

Following the Active Governance workshop held on 2 November 2021, a review of the IPQR started with the establishment of an IPQR review group. The key early changes requested by this group were the creation of a Public Health & Wellbeing section of the report and the inclusion of Statistical Process Control (SPC) charts for applicable indicators.

The list of indicators has been amended, with the most recent addition being for Adverse Events Closure Rate, in the Clinical Governance section. A further addition relating to Establishment Gap (Staff Governance) is being considered.

A summary of the Corporate Risks has been included in this report. Risks are aligned to Strategic Priorities and linked to relevant indicators throughout the report. Risk level has been incorporated into Indicator Summary, Assessment section and relevant drill-downs if applicable.

The final key change identified was the production of different extracts of the IPQR for each Standing Committee. The split enables more efficient scrutiny of the performance areas relevant to each committee and was introduced in September 2022.

2.3 Assessment

Performance has been hugely affected during the pandemic. To support recovery, NHS Fife is progressing the targets and aims of the 2022/23 Annual Delivery Plan (ADP), which was submitted to the Scottish Government at the end of July 2022.

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

Measure	Update	Local/National Target	Current Status
Adverse Events [1]	Monthly	TBD	TBD
HSMR	Quarterly	1.00 (Scotland average)	Below Scottish average
Falls [2]	Monthly	6.91 per 1,000 TOBD	Not achieving
Pressure Ulcers [2]	Monthly	0.89 per 1,000 TOBD	Not achieving
SAB (HAI/HCAI)	Monthly	18.8 per 100,000 TOBD	Achieving
ECB (HAI/HCAI)	Monthly	33.0 per 100,000 TOBD	Achieving
C Diff (HAI/HCAI)	Monthly	6.5 per 100,000 TOBD	Not achieving
Complaints (S1)	Monthly	80%	Not achieving
Complaints (S2) [3]	Monthly	50%	Not achieving

[1] Reporting on the closure rate of Major & Extreme Adverse Events started in December 2022; discussions on a performance target are in progress

[2] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2022/23. These are a 10% reduction on the FY 2021/22 target

for Falls, and a 25% reduction on the actual achievement in FY 2020/21 for Pressure Ulcers.

[3] An improvement target of 50% by March 2023, rising to 65% by March 2024 was agreed by the Director of Nursing. However, performance has been very much lower than the 50% provisional target, generally due to closing long-term complaints. A further measure (Stage 2 Complaints Raised in Month and Closed Within 20 Working Days) has been added. This is still being developed but has no target.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

Financial aspects are covered by the appropriate section of the IPQR.

2.3.4 Risk Assessment/Management

A mapping of key Corporate Risks to measures within the IPQR is provided via a Risk Summary Table and the Executive Summary narratives.

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

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

The Clinical Governance extract of the February IPQR will be available for discussion at the meeting on 3 March.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 16 February and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

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

- **Assurance**
- **Discussion** – Examine and consider the NHS Fife performance as summarised in the IPQR

3 List of appendices

- Appendix 1 - IPQR

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Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Produced in February 2023

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National Standards and local Key Performance Indicators (KPI).

Amendments have been made to the IPQR following the IPQR Review. This involves changes to the suit of key indicators, a re-design of the Indicator Summary, applying Statistical Process Control (SPC) where appropriate and mapping of key Corporate Risks.

At each meeting, the Standing Committees of the NHS Fife Board is presented with an extract of the overall report which is relevant to their area of Governance. The complete report is presented to the NHS Fife Board.

The IPQR for the Clinical Governance Committee comprises the following:

a) **Corporate Risk Summary**
Summarising key Corporate Risks and status.

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

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

d) **Assessment**
Summary assessment for indicators of continual focus.

e) **Performance Exception Reports**
Further detail for indicators of focus or concern. Includes additional data presented in tables and charts, incorporating SPC methodology, where applicable. Deliverables, detailed within Annual Delivery Plan (ADP) 2022/23, relevant to indicators are incorporated accordingly.

Statistical Process Control (SPC) methodology can be used to highlight areas that would benefit from further investigation – known as 'special cause variation'. These techniques enable the user to identify variation within their process. The type of chart used within this report is known as an XmR chart which uses the moving range – absolute difference between consecutive data points – to calculate upper and lower control limits. There are a set of rules that can be applied to SPC charts which aid to interpret the data correctly. This report focuses on the 'outlier' rule identifying whether a data point exceeds the calculated upper or lower control limits.

MARGO MCGURK
Director of Finance & Strategy
16 February 2023

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

a. Corporate Risk Summary

To be cross referenced with in depth Risk Report presented at Committees and NHS Board

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◀ ▶	High
To improve the quality of health and care services	5	5	-	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	**18**	**14**	**4**	**0**	**0**		

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities facing a risk profile in excess of risk appetite.

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

Risk Improvement Trajectory for high risks and Corporate Risk Register assessment in place.

Risk Key

High Risk	15 - 25
Moderate Risk	8 - 12
Low Risk	4 - 6
Very Low Risk	1 - 3

Movement Key

▲ Improved - Risk Decreased

◀ ▶ No Change

▼ Deteriorated - Risk Increased

b. Indicator Summary

Section	Indicator	Target 2022/23	Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Benchmarking	
Clinical Governance	Major/Extreme Adverse Events - Number Reported	N/A	Month	Dec-22	39	○	▲	▼	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	TBD	Month	Dec-22	37.0%	●	▼	▼	●	
	HSMR	N/A	Year Ending	Jun-22	0.99	●	▲	▲	●	
	Inpatient Falls	6.91	Month	Dec-22	7.50	○	▼	▲	●	
	Inpatient Falls with Harm	1.65	Month	Dec-22	2.07	○	▼	▼	●	
	Pressure Ulcers	0.89	Month	Dec-22	1.22	○	▼	▲	●	
	SAB - HAI/HCAI	18.8	Month	Dec-22	3.2	○	▲	▲	●	QE Sep-22
	C Diff - HAI/HCAI	6.5	Month	Dec-22	13.0	○	▼	▼	●	QE Sep-22
	ECB - HAI/HCAI	33.0	Month	Dec-22	22.7	○	▲	▲	●	QE Sep-22
	S1 Complaints Closed in Month on Time	80%	Month	Dec-22	48.7%	○	▲	▼	●	2021/22
	S2 Complaints Closed in Month on Time	50%	Month	Dec-22	17.9%	○	▲	▲	●	2021/22
	S2 Complaints Opened in Month and Closed On Time	N/A	Month	Dec-22	18.4%	○	▲	▲	●	
Operational Performance	IVF Treatment Waiting Times	90%	Month	Dec-22	100.0%	●	◀▶	◀▶		
	4-Hour Emergency Access	95%	Month	Jan-23	69.6%	○	▲	▼	●	Dec-22
	Patient TTG % <= 12 Weeks	100%	Month	Dec-22	50.3%	●	▼	▼	●	Sep-22
	New Outpatients % <= 12 Weeks	95%	Month	Dec-22	45.8%	●	▼	▼	●	Sep-22
	Diagnostics % <= 6 Weeks	100%	Month	Dec-22	53.3%	●	▼	▼	●	Sep-22
	18 Weeks RTT	90%	Month	Dec-22	68.6%	●	▲	▼	●	QE Sep-22
	Cancer 31-Day DTT	95%	Month	Dec-22	94.4%	○	▼	▼	●	QE Sep-22
	Cancer 62-Day RTT	95%	Month	Dec-22	65.8%	○	▼	▼	●	QE Sep-22
	Detect Cancer Early	29%	Year Ending	Mar-22	22.2%	●	▼	▲	●	2020, 2021
	Freedom of Information Requests	85%	Month	Jan-23	94.1%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Jan-23	10.5%	●	▲	▲	●	QE Jun-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Jan-23	5.3%	○	▲	▲	●	QE Jun-22
	Antenatal Access	80%	Month	Dec-22	86.1%	●	▼	▲	●	CY 2021
Finance	Revenue Resource Limit Performance	(£10.4m)	Month	Dec-22	(£22.6m)	●	▼	—	●	
	Capital Resource Limit Performance	£29.5m	Month	Dec-22	£20.7m	●	—	—	●	
Staff Governance	Sickness Absence	4.00%	Month	Dec-22	7.85%	○	▼	▼	●	YE Mar-22
	Personal Development Plan & Review (PDPR)	80%	Month	Jan-23	32.3%	●	▼	—	●	
Public Health & Wellbeing	Smoking Cessation (FY 2022/23)	473	YTD	Sep-22	143	●	—	▼	●	Q/E Jun-22
	CAMHS Waiting Times	90%	Month	Dec-22	59.3%	○	▼	▼	●	QE Sep-22
	Psychological Therapies Waiting Times	90%	Month	Dec-22	73.8%	○	▼	▼	●	QE Sep-22
	Drugs & Alcohol Waiting Times	90%	Month	Nov-22	96.7%	●	▼	▲	●	QE Sep-22
	COVID Vaccination (Autumn/Winter Booster, Age 65+)	80%	Month	Jan-23	89.6%	●	▲	—	●	
	Flu Vaccination (Age 65+)	80%	Month	Jan-23	87.8%	●	▲	—	●	
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Sep-22	94.4%	○	▼	▼	●	QE Sep-22
	Immunisation: MMR2 at 5 Years	92%	Quarter	Sep-22	88.4%	○	▼	▼	●	QE Sep-22

Performance Key

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

SPC Key

- ○ Within control limits
- ○ Special cause variation, out with control limits
- ● No SPC applied

Change Key

- ▲ "Better" than comparator period
- ◀▶ No Change
- ▼ "Worse" than comparator period
- — Not Applicable

Benchmarking Key

- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile
- ● Not Available

c. Projected and Actual Activity

Better than Projected | Worse than Projected | No Assessment
(NOTE: Better/Worse may be higher or lower, depending on context)

		Quarter End Jun-22	Quarter End Sep-22	Quarter End Dec-22	Month End Jan-23	Month End Feb-23	Month End Mar-23	Quarter End Mar-23
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	3,036	3,053	3,087	1,029	1,029	1,029	3,087
	Actual	2,878	2,996	3,146	1,022			1,022
	Variance	-158	-57	59	-7			
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	18,567	18,806	19,156	6,376	6,395	6,395	19,166
	Actual	20,951	21,448	21,808	7,397			7,397
	Variance	2,384	2,642	2,652	1,021			
Urgent	Actual	10,868	11,377	11,301	3,642			3,642
Routine	Actual	10,083	10,071	10,507	3,755			3,755
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,491	1,491	1,491	497	497	497	1,491
	Actual	1,550	1,608	1,678	556			556
	Variance	59	117	187	59			
Upper Endoscopy	Actual	575	630	640	238			238
Lower Endoscopy	Actual	182	191	206	64			64
Colonscopy	Actual	738	742	770	238			238
Cystoscopy	Actual	55	45	62	16			16
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	11,988	11,988	11,988	3,996	3,996	3,996	11,988
	Actual	13,471	12,936	11,875	4,238			4,238
	Variance	1,483	948	-113	242			
CT Scan	Actual	4,083	3,989	3,619	1,262			1,262
MRI	Actual	2,936	2,923	2,654	916			916
Non-obstetric Ultrasound	Actual	6,452	6,024	5,602	2,060			2,060

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services

5

5	-	-	-

◀ ▶

Moderate

		Target	Current
Major & Extreme Adverse Events	*70% of Action from Major and Extreme Adverse Events to be closed within time*	**70%**	**37.0%**

There were 39 major/extreme adverse events reported in December, the lowest monthly figure since August but remaining above the 2-year average of 35. A total of 1,375 incidents were registered in the month. Looking at SAER/LAER actions, 10 out of 27 (37%) were closed on time in the month, a fall of nearly 10% compared to November.

The accumulation of open SAER/LAER on top of a slight increase in numbers of newly commissioned SAER/LAER is presenting a significant management challenge to services that are already under pressure. There is a risk that learning is not being identified and acted on in a timely fashion, with SAER reviews exceeding the 90 day expected completion time.

Following discussion at the Clinical Governance Oversight Group a decision has been made to trial a change in the process around the executive review and approval of SAER to reduce the time commitment of review teams and improve efficiency. A review of the new process will be considered at the end of March.

HSMR		**1.00**	**0.99**

Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2022 showing a ratio below the Scottish average.

Inpatient Falls	*Reduce all patient falls rate by 10% in FY 2022/23 compared to the target for FY 2021/22*	**6.91**	**7.50**

The number of inpatient falls in ASD reduced in December but increased across the Partnership and the overall rate remained higher than target for March although significantly better than in December 2021 (8.25). The rate in FY 2022/23 to date is 7.36; for the same period of FY 2021/22, it was 7.72. This reduction is driven primarily by fall in rate within the Partnership.

The majority of falls in the last 3 months (95%) were classified as 'Minor Harm' or 'No Harm' but the actual number resulting in Major/Extreme Harm in December was the highest since we started reporting on this at the start of 2020.

The updated Falls Toolkit is ready for launch in March. Learning Summaries were discussed at the February meeting which resulted in a decision to discuss further with the Organisational Learning Group (chaired by Nicola Robertson). A Sub-group is to be developed to review Quality Improvement Data Display in wards.

Pressure Ulcers	*Reduce pressure ulcer rate by 25% in FY 2022/23 compared to the rate in FY 2021/22*	**0.89**	**1.22**

The rate of pressure ulcers increased in December when it was the highest for 6 months and above the 2-year average (1.15). The increase was due to a particularly high number of PU in ASD, which continues to report a significantly higher number and rate of PU than the Partnership.

The cumulative rate in the first 9 months of FY 2022/23 was slightly less than for the same period in FY 2021/22 (1.10 against 1.17) but remains above the target for FY 2022/23. On the positive side, the ASD rate is lower when comparing the two periods.

The HSCP tissue viability team are developing a link practitioner model that is relevant and open to care home staff and will work closely with the care home liaison team. The team channel open to link practitioners is being well used at present and supported by TVN team.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**18.8**	**3.2**

The SAB infection rate varies from month to month and has been below the March 2023 target in 7 of the 9 months of FY 2022/23 to date, most recently in December when there was only a single infection reported. Of the 37 HAI/HCAI reported in FY 2022/23, only 8 have been categorised as VAD while just under half (15) have been categorised as 'Other / Not Known'.

The last quarterly HAI report from Health Protection Scotland, covering the quarter ending September 2022, showed that NHS Fife was in the mid-range of all Mainland Health Boards, with a rate of 15.7 against a Scottish average of 17.1.

		Target	Current

Fife has been below the Scottish average for 8 successive quarters. This has been achieved by enhanced surveillance of SAB, standardising vascular access devices (VAD) care, the implementation of ePVC insertion and maintenance bundles and targeted QI work.

The IPCT performs the following actions:

- Enhanced surveillance and analysis of SAB data to understand the magnitude of the risks to patients in Fife
- Timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs
- Examination of the impact of interventions targeted at reducing SABs
- Uses results locally for prioritising resources
- Uses data such as the weekly ePVC compliance report to inform clinical practice improvements
- Continues to liaise and support Drug Addiction Services with people who inject drugs (PWID) and SABs

  Note: 2022 has seen a marked increase in PWIDs cohort SAB infections (n=11), when compared to 2021 (n=4)

In order to maintain such low rates and to further reduce SABs, the local and national intelligence highlights the following areas for focus; medical devices (including VADs) and non-vascular access medical devices, skin & soft tissue infections (including PWIDs).

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**6.5**	**13.0**

The C Diff infection rate varies from month to month but has been above the March 2023 target for much of FY 2022/23 with a high number of HAI/HCAI reported in both November and December. A key improvement aim is the reduction of 'recurrent' infections, and this continues to be a challenge, with 5 of the 40 HAI/HCAI and Community infections in the past year being identified under this category.

The last quarterly HAI report from Health Protection Scotland, covering the quarter ending September 2022, showed that NHS Fife had the second lowest infection rate (10.1) of all Mainland Health Boards, Scottish average 13.1.

Fife has been below the Scottish average for each of the last 14 quarters. This has been achieved with strong antimicrobial stewardship, Consultant Microbiologist establishing optimum antimicrobial therapy for patients at high risk of recurrent CDI, enhanced surveillance and analysis of risk factors.

The challenge is to further reduce the noted low rates of CDI. Work focuses on recurrent CDI (2022 equalled the previous year with the number of recurrent infections); each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high-risk patients. Bezlotoxumab has been used in cases where other modalities have failed.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2023*	**33.0**	**22.7**

The ECB infection rate varies from month to month and has been below the March 2023 target in 3 out of 9 months of FY 2022/23 to date, including both November and December. The cumulative rate for the first 9 months of FY2022/23 was 35.9, a 15% reduction compared to the first 9 months of FY 2021/22 (42.3).

Urinary Catheter-related infections have been responsible for 33 of the 123 infections in the last year (27%) and remains a key focus for improvement work.

The last quarterly HAI report from Health Protection Scotland, covering the quarter ending September 2022, showed that NHS Fife (36.9) lay in the mid-range of Mainland Health Boards, slightly above the Scottish average (36.2).

The total number of HCAI ECB cases in 2022 was slightly lower than the previous 2 years (2022 n=123, 2021 n=127 and 2020 n=137) However, Q3 2022 National Report, Fife was slightly above the Scottish rate for HCAI. In both hospital-acquired and non-hospital-acquired infections, the renal tract is the major source of infection (with cystitis/lower UTI the major entry point) along with hepato-biliary infections.

To achieve the reduction target, NHS Fife continues to focus on enhanced surveillance, to gain learning, evaluate preventative measures and improve practices. One current initiative within the HSCP includes the Infection Control Surveillance team alerting the patient`s care team Manager by Datix when an ECB is a urinary catheter associated infection and exploring the case via a Complex Care Review (CCR). The aim of the process is to provide further learning from all ECB CAUTIs.

Ongoing work to support best practice in urinary catheter care continues with NHS Fife`s Urinary Catheter Improvement Group (UCIG) targeting quality improvement work. This group aims to minimize urinary catheters, thus helping to prevent catheter associated healthcare infections and trauma and, furthermore, to establish catheter improvement work in Fife.

CAUTI insertion and maintenance bundles were developed and installed onto Patientrack in February 2022 and this is being piloted prior to roll out across the board. This bundle should ensure that the correct processes for the insertion and maintenance of all urinary catheters are adhered to within NHS Fife inpatient wards. Acute services engagement and a HoN lead will be required to assist the further roll out.

A QI project led by the IPC Care Home Senior IPCN for NHS Fife has introduced CAUTI maintenance bundles within 4 care homes in Fife. The staff are supported with an education package and the aim is to eventually roll it

		Target	Current
out across all Fife care homes, thus optimising urinary catheter maintenance and reducing the risk of CAUTIS and ECBs.			
Complaints – Stage 2	*At least 50% of Stage 2 complaints will be completed within 20 working days by March 2023, rising to 65% by March 2024*	**50%**	**17.9%**

Work is continuing to develop further measures in order to provide a more rounded view of activity and performance. Measures are available to identify both the compliance with complaints due for closure in month, as well as the 'formal' measure which looks at all complaints closed in month, regardless of when they were opened.
In December, 17.9% of Stage 2 complaints due in month (n=28) were closed within the 20-day target. Of all 38 closures in December, 18.4% were within the 20-day target, the highest figure since January 2022.

The total number of Stage 2 Complaints closed in FY 2022/23 to date is 333, 52 more than in the same period of FY 2021/22.

The Patient Experience Team (PET) has developed processes to identify where system delays occur within the complaints process. Digital information was unable to identify solutions to support a shared platform/document, which would help to streamline the complaints process and improve statements and final response approval times.

To improve the quality of complaint response, the PET will establish revised processes to clearly identify Heads of Complaint.

Preliminary discussions continue to take place to explore a live complaints data dashboard. Data and Screenshots from another health board's dashboard have been sent to digital information, and this will be reviewed along with current static reports from Business Objects reporting software.

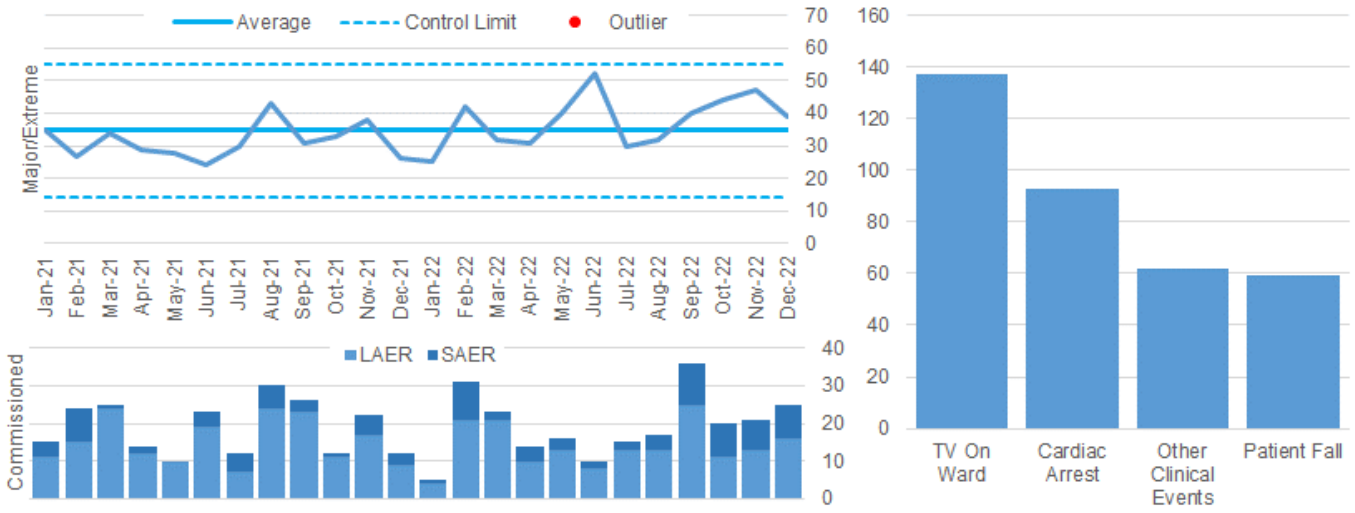
Two Band 6 fixed term 6-month Patient Experience Team Officers have been recruited and will commence in February and March. We are currently recruiting a Band 4 Patient Experience Administrator to focus on the administration and navigation of complaints.

We continue to work with services and review new ways of working. Community Care and Service have set up a central generic HUB email address for complaints which is working well. Weekly meetings are held within the acute to review all stage 2 complaints, and initial discussions have taken place with HSCP to hold similar meetings.

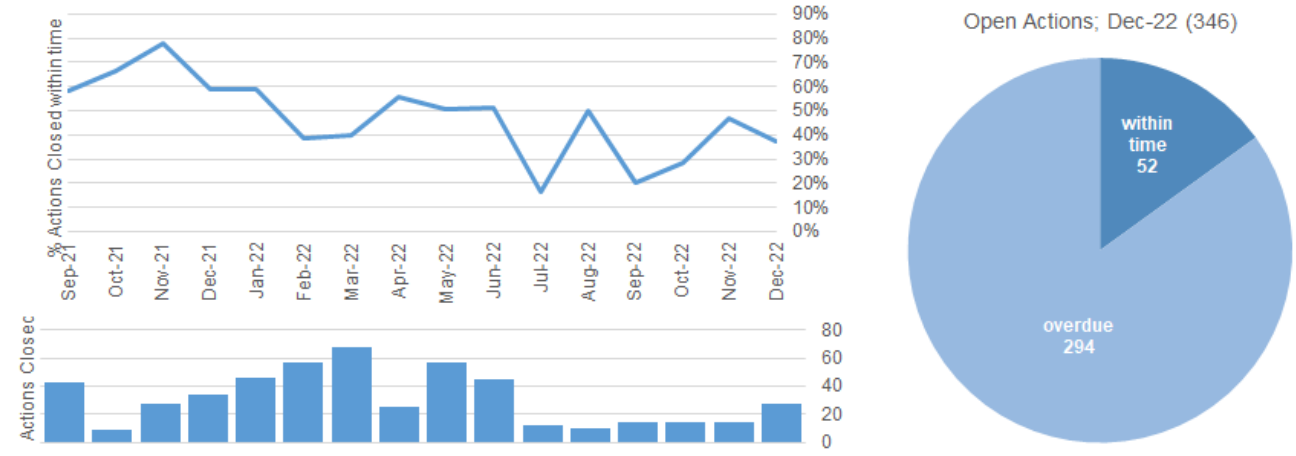
Increased clinical pressures continue to impact performance. At the end of January, 88% of all live complaints were either awaiting statements or final approval by the divisions. The number of live complaints has reduced from 156 to 141 in the past quarter despite 89 new complaints being submitted during that period.

e. Performance Exception Reports

Adverse Events	Number 39



Actions from Significant and Local Adverse Event Reviews	Closure Rate 37.0%



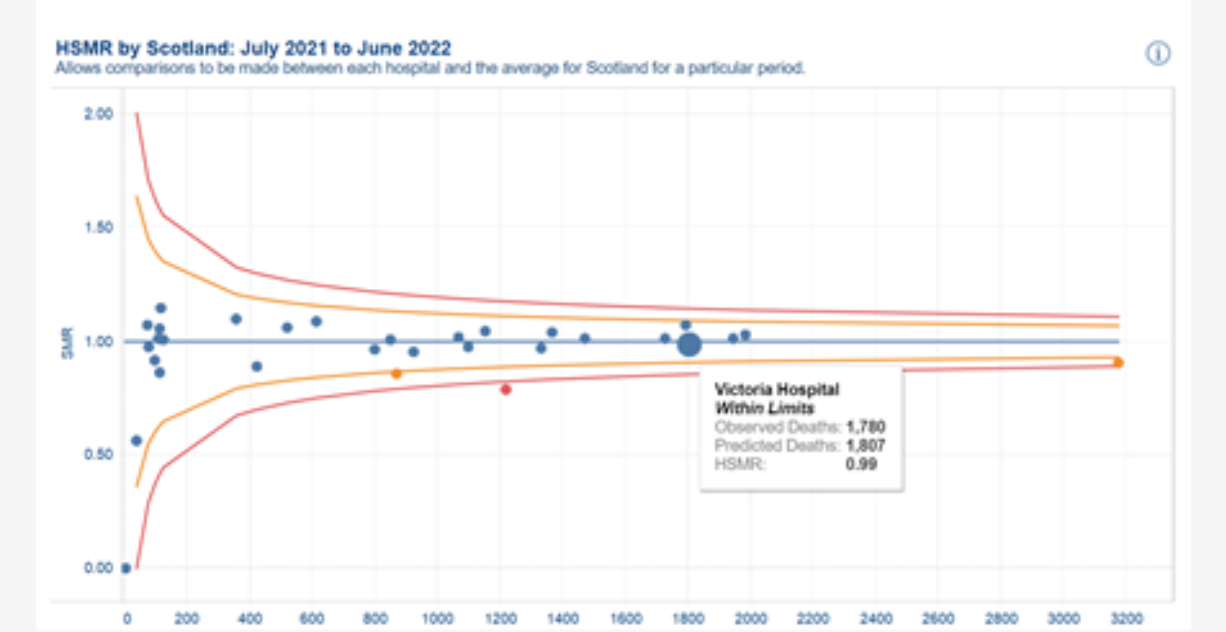
Key Deliverable		End Date
Adverse Event Process and Policy		Mar-23 On track
Key Milestones	Review of Policy	Dec-23 Complete
	Increased focus on governance/assurance in relation to improvement actions from adverse events reviews	Mar-23 On track
	Training and Education	Mar-23 On track

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.*	Performance 0.99

Reporting Period; July 2021 to June 2022[p]

Please note that as of August 2019, HSMR is presented using a 12-month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

The rate for Victoria Hospital is shown within the Funnel Plot.



Commentary

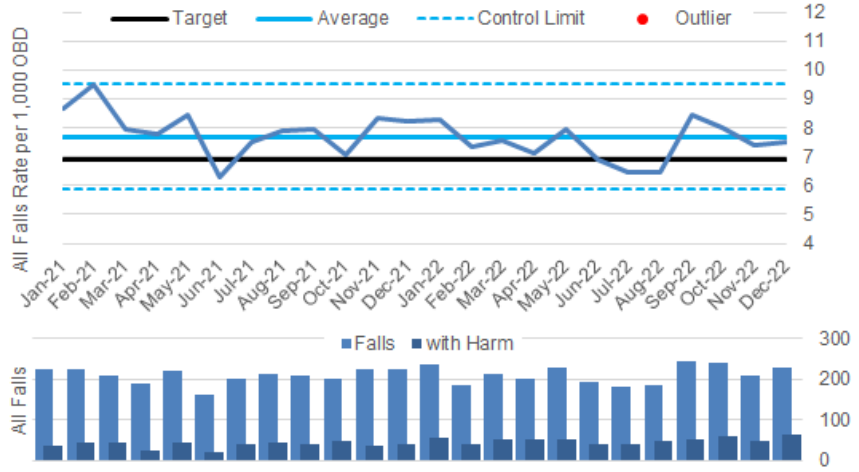
Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2022 showing a ratio below the Scottish average.

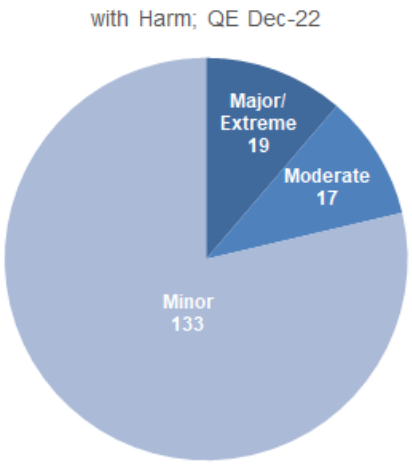
Inpatient Falls

Reduce Inpatient Falls rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2023) = 6.91 per 1,000 OBD

Performance 7.50

Local Performance





Performance by Service Area

	2021/22			2022/23								
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NHS Fife	8.29	7.33	7.59	7.13	7.94	6.91	6.44	6.45	8.44	8.00	7.37	7.50
Acute Services	9.32	7.55	7.10	8.25	8.18	7.83	8.06	6.67	9.56	7.81	8.29	7.34
HSCP	7.41	7.16	8.01	6.14	7.72	6.08	4.97	6.25	7.47	8.18	6.58	7.65

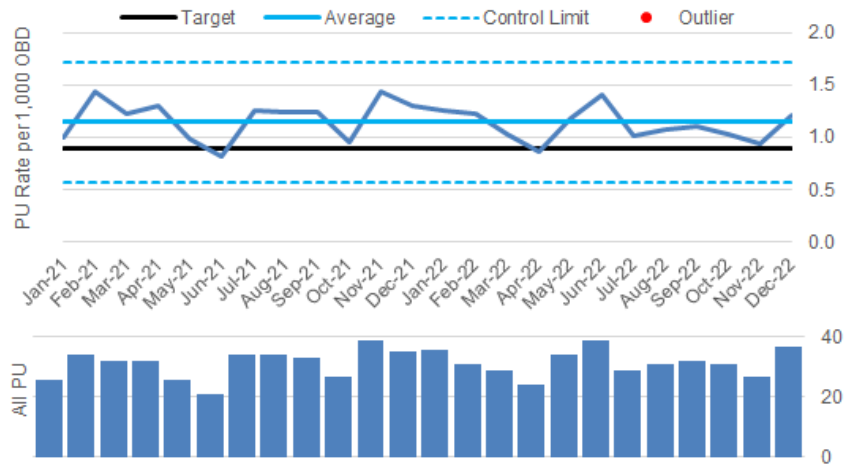
Key Deliverable	End Date
Reduction in number of Patient Falls in order to achieve specified reduction target in this FY	Mar-23 On track
Key Milestones	
Refresh Falls Champions Register and Network	Jan-23 On track
Ensure that monthly falls data continues to be discussed and displayed in each ward setting along with associated improvement plans	Mar-23 At risk
Develop an Audit programme for 2022/23	Jun-22 Complete
Review and refresh Falls Toolkit	Apr-23 Complete
Review Related policies- Supervision, Boarding and Bed rails as identified/required by the policy timescales	Feb-23 On track
Review LEARN summaries to support shared learning	May-23 On track
Explore feasibility of implementation of Falls module on Patient Trak	Mar-23 At risk
Explore QI resource to support clinical staff and enhance local improvement work	Feb-23 On track

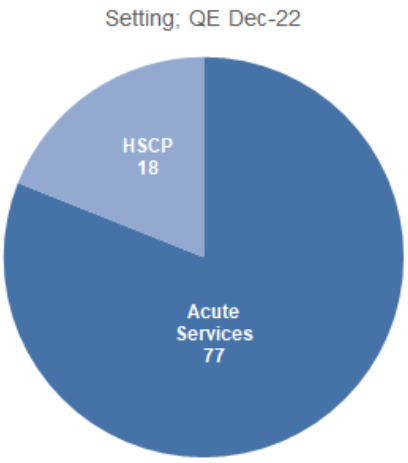
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2023) = 0.89 per 1,000 OBD

Performance 1.22

Local Performance





Performance by Service Area

	2021/22			2022/23								
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NHS Fife	1.25	1.23	1.03	0.87	1.18	1.40	1.02	1.07	1.11	1.03	0.94	1.22
Acute Services	2.10	1.84	1.76	1.37	1.77	2.05	1.48	1.69	2.02	1.90	1.36	2.20
HSCP	0.52	0.72	0.40	0.41	0.66	0.82	0.60	0.52	0.32	0.25	0.59	0.32

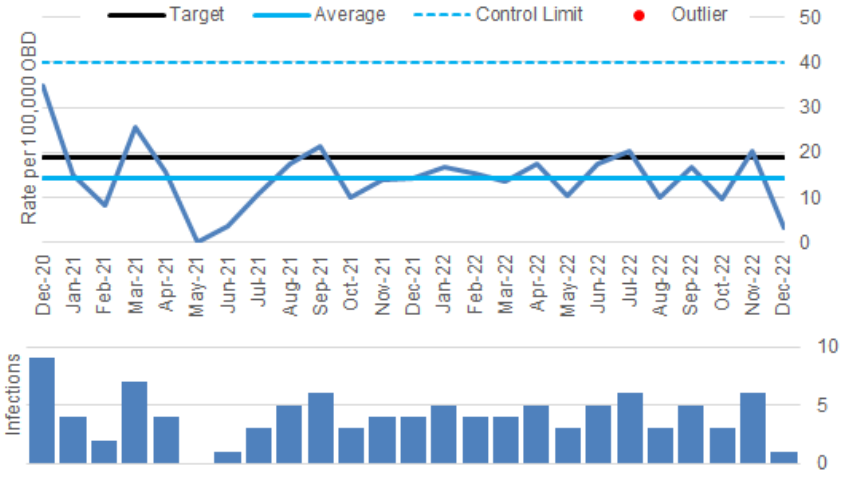
Key Deliverable	End Date
Reduction in number of Pressure Ulcers (PU) developed on case load across all health care setting in order to achieve specified reduction target in this FY	Mar-23 Off track
Key Milestones Refresh PU Link Practitioner Register and Network	Oct-22 Complete
Ensure that monthly PU data continues to be discussed and displayed in each ward setting, associated improvement plans developed and implemented where required	Mar-23 At risk
PU data discussed and shared with senior HSCP management team at bi-weekly QMASH meeting	Mar-23 Complete
PU Documentation Audit to support compliance	Mar-23 On track
Review LEARN summaries to support shared learning	Mar-23 On track
Measurement against the revised HIS Prevention and Management of Pressure Ulcer Standards (October 2020)	Mar-23 At risk
Establish an operational TV group	Jan-23 Off track
Embed the revised HIS Pressure Ulcer Standards (October 2020)	Oct-23 Suspended
Develop and test electronic PURA and SSKIN bundle on Patientrack	Oct-22 Complete
Embed the use of the CAIR resource	Mar-23 On track
Clinical teams with an increase in PU harms to collect process measures to identify and plan improvements	Mar-23 On track
Develop a training and education plan	Oct-22 Complete

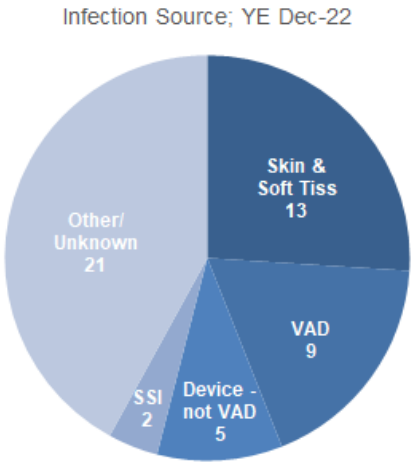
SAB (HAI/HCAI)

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

Performance 3.2

Local Performance





National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	17.8	6.3	16.6	12.7	15.2	14.9	15.7
Scotland	18.4	18.6	18.3	17.3	16.3	17.3	17.1

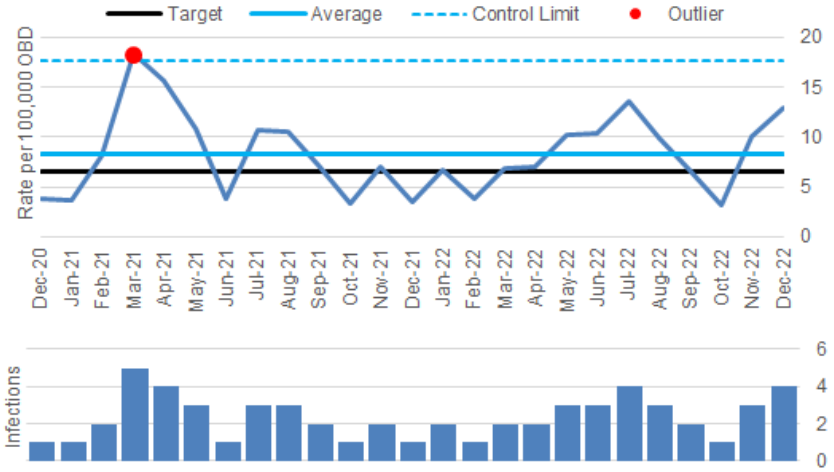
Key Deliverable	End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement	Mar-23 On track
Programme of audit; monitor IPC standard operating procedures, guidelines and practice 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 On track

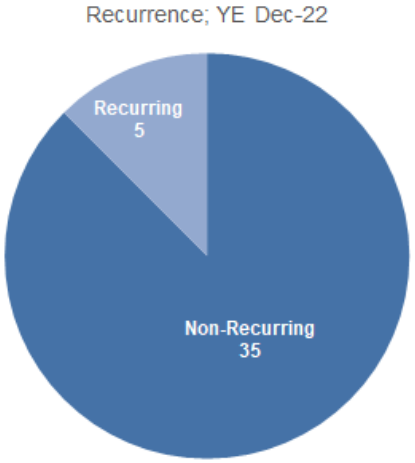
C Diff (HAI/HCAI)

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

Performance 13.0

Local Performance





National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	14.0	10.0	9.5	4.6	7.0	9.2	10.1
Scotland	15.8	14.6	16.8	13.3	12.6	14.3	13.1

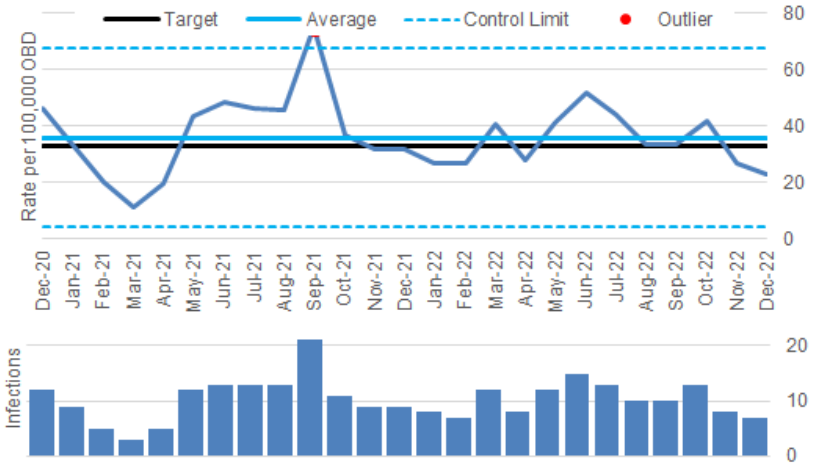
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 On track
	Reduce overall prescribing of antibiotics	Mar-23 On track
	Reducing recurrence of CDI	Mar-23 At risk
Programme of audit; monitor IPC standard operating procedures, guidelines and practice in all patient care areas using the agreed tools to a pre-set plan, with feedback of findings provided in the form of written reports/ action plans		Mar-23 At risk
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-23 On track

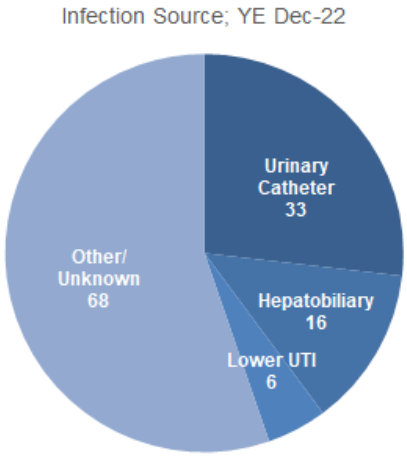
ECB (HAI/HCAI)

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

Performance 22.7

Local Performance





National Benchmarking

Quarter Ending	2020/21	2021/22				2022/23	
	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	21.6	37.6	60.3	33.6	31.6	40.2	36.9
Scotland	34.7	38.2	41.5	34.1	30.5	34.8	36.2

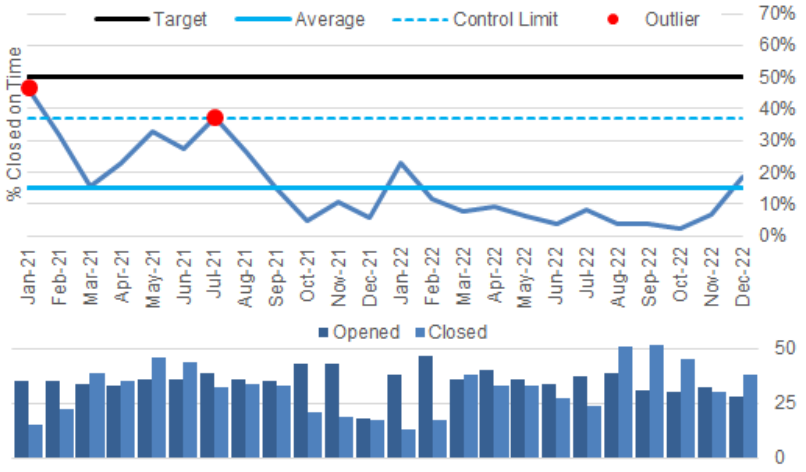
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 On track
	Ongoing work of Urinary Catheter Improvement Group (UCIG) eCatheter insertion & maintenance bundle on Patientrack- further rollout	Mar-23 At risk
	Enhanced surveillance - led by Consultant Microbiologist	Mar-23 At risk
Programme of audit; monitor IPC standard operating procedures, guidelines and practice in all patient care areas using the agreed tools to a pre-set plan, with feedback of findings provided in the form of written reports/ action plans		Mar-23 At risk
IPC Education & training: Infection Prevention and Control knowledge and training for staff are fundamental for safe patient care		Mar-23 On track

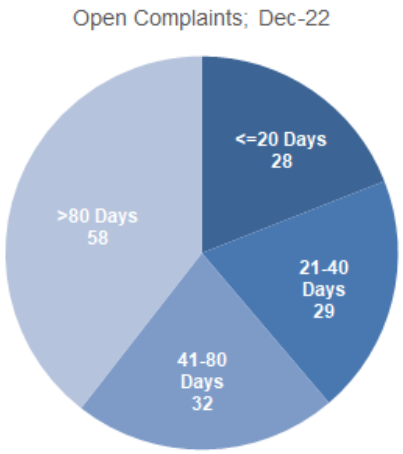
Complaints | Stage 2

At least 50% of Stage 2 complaints are completed within 20 working days by March 2023, rising to 65% by March 2024

Performance 17.9%

Local Performance





Performance by Service Area

		2021/22			2022/23								
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHS Fife	Opened in Month	38	47	36	40	36	34	37	39	31	30	32	28
	Due in Month	17	40	44	37	49	33	30	47	37	21	31	28
	% Closed on time	0.0%	12.5%	6.8%	5.4%	4.1%	6.1%	3.3%	6.4%	5.4%	4.8%	3.2%	17.9%
	Closed in Month	13	17	38	33	33	27	24	51	52	45	30	38
	% Closed on time	23.1%	11.8%	7.9%	9.1%	6.1%	3.7%	8.3%	3.9%	3.8%	2.2%	6.7%	18.4%
	% Acknowledged (3 days)	92.1%	80.9%	94.4%	92.5%	69.4%	76.5%	81.1%	87.2%	90.3%	96.7%	87.5%	89.3%
Acute Services	Due in Month	11	27	31	29	35	18	23	35	26	14	20	20
	% Closed on time	0	0	0	0	0	0	0	0	0	0	0	0
	Closed in Month	10	11	28	25	22	20	14	43	34	29	22	28
	% Closed on time	30.0%	18.2%	3.6%	12.0%	4.5%	5.0%	14.3%	2.3%	0.0%	0.0%	9.1%	21.4%
HSCP	Due in Month	6	13	10	7	13	15	7	10	10	7	10	8
	% Closed on time	0.0%	0.0%	10.0%	0.0%	0.0%	6.7%	0.0%	0.0%	10.0%	14.3%	0.0%	0.0%
	Closed in Month	3	3	7	7	11	7	10	6	16	16	7	10
	% Closed on time	0.0%	0.0%	14.3%	0.0%	9.1%	0.0%	0.0%	0.0%	6.3%	6.3%	0.0%	10.0%

Key Deliverable	End Date
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017)	Mar-24 Off track
Adherence to NHS Fife's Participation and Engagement Framework	Mar-23 Complete
Rebrand Patient Relations to Patient Experience Team	Dec-22 Complete

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for February 2023 committee 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 February 2023 committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT circulated to the Infection Control Committee February 2023.

2.2 Background

Infection Prevention and Control provide a service to NHS Fife including a planned programme of visits, audit, education and support is provided to staff on an ongoing as well as a National programme of Surveillance for Surgical Site Infections, *Clostridiodies difficile* infection (CDI), *Staphylococcus aureus* bacteraemia (SAB) and *E. coli* bacteraemia (ECB).

Standards on Reduction of Healthcare Associated Infections:
DL (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 Q3 2022 (Jul-Sep), NHS Fife was below the national rate for healthcare associated infection (HCAI), but above for community associated infection (CAI).
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.
- There have been 11 PWID SABs during the time period January-December 2022, this is significantly higher than the number of cases that were reported during 2021 (n=4).

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

- Collect and analyse SAB data on a monthly basis to understand the magnitude of the risks to patients in Fife.
- Provide timely feedback of data to key stakeholders to assist teams in minimising the occurrence of SABs where possible.
- Examine the impact of interventions targeted at reducing SABs.
- Use results locally for prioritising resources.
- Use data to inform clinical practice improvements thereby improving the quality of patient care.
- Liaise with Drug addiction services re PWID (IVDU) SABs. The most recent meeting took place on 16/01/23.

CDI

- During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for HCAI & CAI.
- The cumulative total of CDIs from Jan- Dec 2022 (40 cases) is lower than during the same time period in 2021, when there were 44 cases, however, the number of Healthcare associated (HAI + HCAI + Unknown) CDIs is slightly higher Jan-Dec 2022 (n=30), when compared to Jan-Dec 2021 (n=28).

Current CDI initiatives

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

ECB

- During Q3 2023 (July-Sep), NHS Fife was above the national rate for HCAI & CAI.
- Considering the time period Jan-Dec 2022, the number of ECBs (277 cases) has risen, compared to the same time period the previous year (Jan-Dec 2021), when there were 249 ECBs. However, the number of HCAI (HAI + HCAI) cases is slightly lower, when comparing Jan-Dec 2022 (123 cases), to Jan-Dec 2021 (127 cases).

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- Patientrack CAUTI bundles still to be implemented for Acute services/HSCP to be trailed on V54 ward & Glenrothes Hospital, 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.
- CAUTI bundles have been implemented within 4 care homes as a trial, with the aim to roll out across all care homes, to optimise urinary catheter maintenance to all care home residents. This work is to be led by the IPC Care Home Senior IPCN for NHS Fife.

COVID-19 pandemic

From ARHAI Scotland weekly report a further spike in probable and definite hospital onset COVID-19 cases were reported across Scotland in December 2022/January2023.

Surgical Site Infection (SSI) Surveillance Programme

National surveillance programme for SSI 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 was due to commence in Q4 2022. Since then, there has been a further delay, and we are awaiting further instruction. Preparation and extra resources will be required prior to this taking place.

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 (Nov – December 2022)

- **Norovirus**

There has been **2** new ward closure due to a Norovirus outbreak

- **Seasonal Influenza**

There has been 3 new closures due to confirmed Influenza

- **COVID-19**

Twenty new 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 via LanQIP dashboard no longer supported by NHS eHealth. IPCT liaising with D&I for a resolution.

Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 3 (Oct - Dec 2022) was **95.9%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct - Dec 2022) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 3 (Oct - Dec 2022) NHS Fife achieving **Green** status.

2.3.1 Quality/ Patient Care

Effective infection prevention and control are essential to the delivery of high quality patient care and to the provision of a clean and safe environment for patients, visitors and other service users.

2.3.2 Workforce

Effective infection prevention and control are essential to the provision of a clean and safe working environment, and to overall staff health and wellbeing.

2.3.3 Financial

No financial costs identified in this report.

2.3.4 Risk Assessment/Management

Challenges and management of any risks to national infection prevention and control guidance discussed throughout report

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Control Committee February 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- HAIRT Report

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 15th February 2023.

(Validated Data up to December 2022)

February 2023

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

***Staphylococcus aureus* Bacteraemia Prevention (SAB)**
During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for healthcare associated infection (HCAI), but above for community associated infection (CAI).

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

During Q3 2022 (Jul-Sep), NHS Fife was below the national rate for HCAI & CAI.

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

During Q3 2022 (Jul-Sep), 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 11 PWID SABs during the time period January-December 2022. This is significantly higher than the number of cases that were reported during 2021 (n=4). IPCT continue to liaise with the Addictions Service and the most recent meeting took place on 16th January 2023.

ECBs

Considering the time-period Jan-Dec 2022, the number of ECBs (277 cases) has risen, compared to the same timeframe the previous year (Jan-Dec 2021), when there were 249 ECBs. However, the number of HCAI (HAI + HCAI) cases is slightly lower, when comparing Jan-Dec 2022 (123 cases), to Jan-Dec 2021 (127 cases).

CDI

The cumulative total of CDIs from Jan-Dec 2022 (40 cases) is lower than during the same time-period in 2021, when there were 44 cases. However, the number of Healthcare associated (HAI + HCAI + Unknown) CDIs is slightly higher Jan-Dec 2022 (n=30), when compared to Jan-Dec 2021 (n=28).

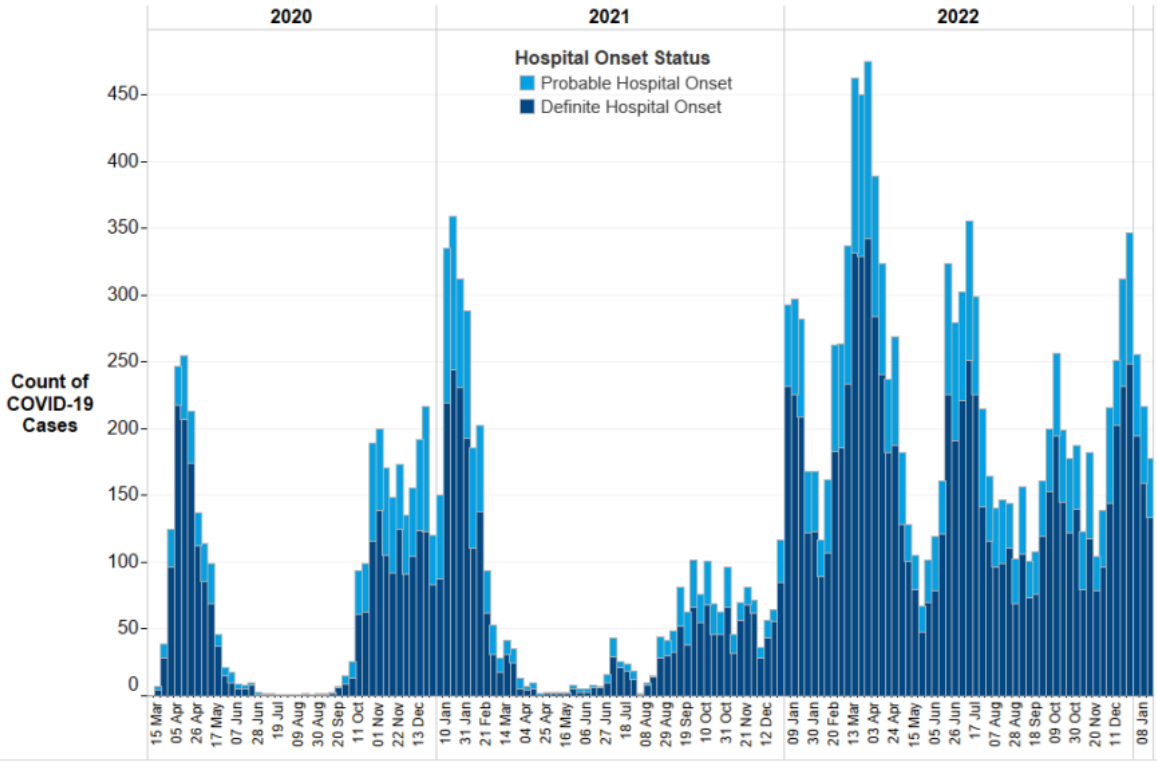
Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopaedic Surgery SSI

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 was due to commence in Q4 2022. Since then, there has been a further delay, and we are awaiting further instruction. Much preparation and extra resources will be required prior to this taking place.

COVID-19

As outlined in Figure 1, a further spike in probable and definite hospital onset COVID-19 cases were reported across Scotland in December 2022/January2023.

Figure 1: Epidemic curve of probable and definite hospital onset COVID-19 cases (first positive specimen of COVID-19 episode taken on day eight of inpatient stay or later), by onset status: week ending 01 March 2020 to week ending 15 January 2023 (n=19,132).[1,2,3]

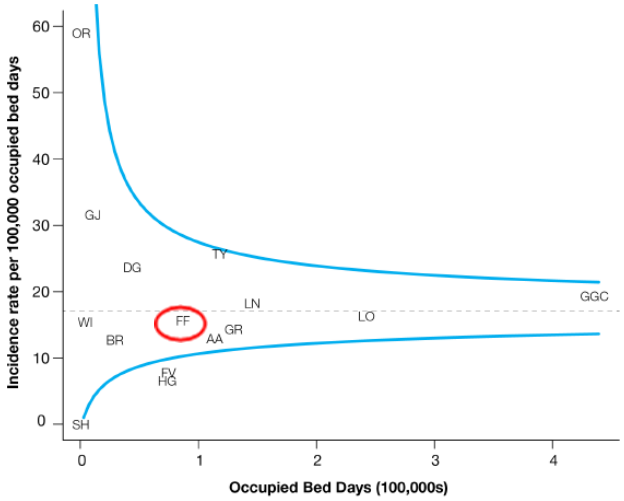
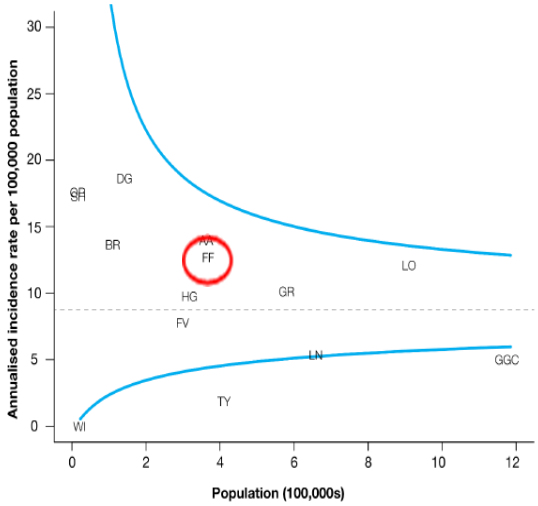


Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q4 2022 (Oct-Dec) **(Q4 2022 National comparison awaited)**				
In Q4 2022 NHS Fife had:	22 SABs	10 HCAI/HAI 12 CAI	This is **LOWER** than:	24 Cases in Q3 2022

Q3 2022 (Jul-Sep) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **15.7**	Per 100,000 bed days	CAI SABs rate: **12.7**	Per 100,000 Pop
No of HCAI SABs: 14		No of CAI SABs: 12	
This is **BELOW** National rate of 17.1		This is **ABOVE** National rate of 8.8	
			
NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.			

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline). This standard 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 Sep 2022 (HPS)			
SAB by rate 100,000 Total bed days	**14.6** per 100,000 TBDs		
SAB by Number of HCAI cases	**51**		

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have been no further dialysis line related SABs in 2022 since the last report. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

As of **01/01/2023** the number of days since the last confirmed SAB is as follows:	
CVC SABs	160 Days
PWID (IVDU)	16 Days
Renal Services Dialysis Line SABs	74 Days
Acute services PVC (Peripheral venous cannula) SABs	77 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 16/01/2023; the Wound Care Protocol was updated early December and PGD training is being rolled out.

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 **100%** compliance with the **MRSA** CRA in Q4 (Oct-Dec) 2022

This was **UP** from 98% in Q3 2022 & **ABOVE** the compliance target of 90%.

Awaiting national comparison for Q4 2022

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

Quarter	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec
Fife	98%	95%	98%	88%	93%	98%	98%	98%	100%
Scotland	82%	83%	84%	81%	82%	81%	80%	78%	N/k

CPE (Carbapenemase Producing Enterobacteriaceae)

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

NHS Fife achieved **100%** compliance with the **CPE** CRA for Q4 2022 (Oct-Dec)

This was equal to the compliance rate in Q3 2022

Awaiting national comparison for Q4 2022

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

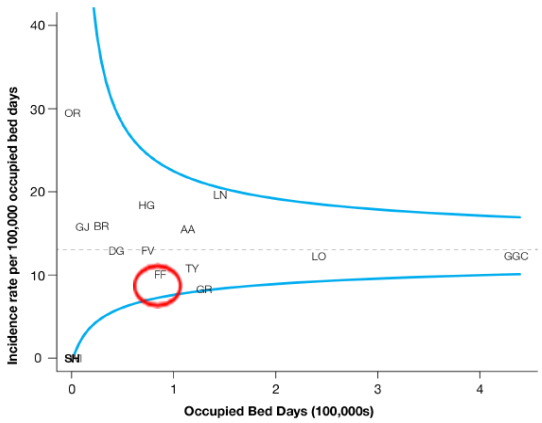
Quarter	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec
Fife	98%	88%	90%	100%	98%	100%	98%	100%	100%
Scotland	79%	82%	83%	82%	80%	80%	79%	78%	N/k

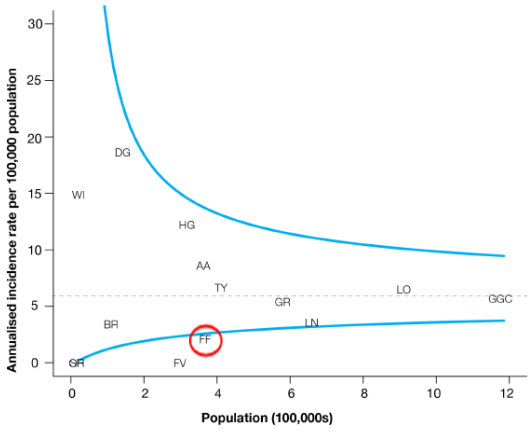
3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dev 2022 **(Q4 2022 HPS National comparison awaited)**				
In Q4 2022 NHS Fife had:	10 CDIs	8 HCAI/HAI/Unknown 2 CAI	This is **DOWN** from	11 Cases in Q3 2022
Q3 (Jul-Sep) 2022 ARHAI validated data with commentary				
With ARHAI Quarterly epidemiological data Commentary *Please note for ARHAI reporting- the CDI denominator may vary from locally reported denominators. This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards.				

Healthcare associated CDIs		Community associated CDIs infection	
HCAI CDI rate: **10.1**	Per 100,000 bed days	CAI CDIs rate: **2.1**	Per 100,000 Pop
No of HCAI CDIs: 9		No of CAI CDIs: 2	
This is **BELOW** National rate of 13.1		This is **BELOW** National rate of 5.9	





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

New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline). This standard 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 September 2022 (HPS)			
CDI by rate 100,000 Total bed days	**7.8** per 100,000 TBDs		
CDI by Number of HCAI cases	**27**		

3.2 Current CDI initiatives

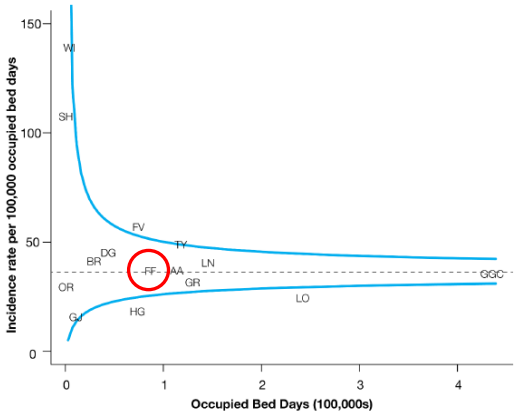
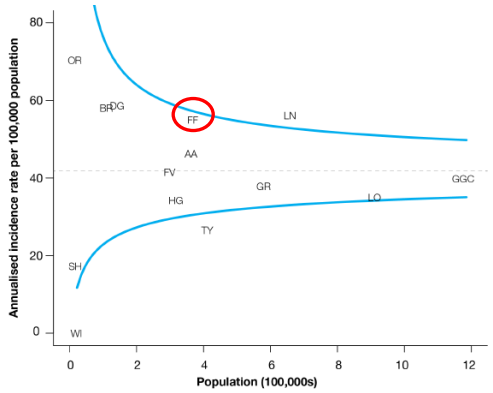
Follow up of all hospital and community cases continues to establish risk factors for CDI

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

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q4 (Oct-Dec) 2022 **(Q3 2022 HPS National comparison awaited)**				
In Q4 2022 NHS Fife had:	64 ECBs	28 HAI/HCAIs 36 CAIs	This is **DOWN** from	77 Cases in Q3 2022
Q4 2022 There were **11** Urinary catheter associated (2 of which were from Suprapubic catheters) ECBs, which was significantly higher than during Q3 2022, when there were 5 CAUTIs.				

Q3 (Jul-Sep) 2022			
HPS Validated data ECBs with HPS commentary *Please note for HPS reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **36.9**	Per 100,000 bed days	CAI ECBs rate: **55.1**	Per 100,000 Pop
No of HCAI ECBs: 33		No of CAI ECBs: 52	
This is **ABOVE** National rate of 36.2		This is **ABOVE** National rate of 41.8	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

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 September 2022 (HPS)		
ECB by rate 100,000 Total bed days	**35.6** per 100,000 TBDs	
ECB by Number of HCAI cases	**124**	

2) 25% Reduction ECBs - 2023/2024		
New standards for reducing all Healthcare Associated ECB by 25% by 2023/2024 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2023/4**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**

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 Q4 2022	TBC	***38%**	* Locally calculated data- TBC by HPS when Q3 & Q4 data published on Discovery
2022 Q3 2022	15.0%	**0%**	
2022 Q2 2022	16.4%	**26.7%***	
2022 Q1	17.6%	**0%**	
2021 TOTAL	16.0%	**15.4%**	
2020 TOTAL	16.4 %	**27.5 %**	
2019 TOTAL	16.1 %	**24.5 %**	
2018 TOTAL	14.5 %	**24.2 %**	
2017 -TOTAL	11.8 %	**10.4 %**	
Data from NSS Discovery ARHAI Indicators			

Healthcare Associated Infections (HCAI)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HCAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2022 Q4 2022	TBC	***40%**	* Locally calculated data- TBC by HPS when Q3 & Q4 data published on Discovery
2022 Q3	23.5%	**20%**	
2022 Q2	20.1%	**35%***	
2022 Q1	21.2%	**33.3 %**	
2021 TOTAL	27.0%	**36%**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
2018 TOTAL	22.1%	**36.6 %**	
2017 TOTAL	18.3 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current 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 in December 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
During 2022, there were 34 (1 case was associated with another board) CAUTI ECBs, of which 6 have been associated with trauma.

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and are due to be trailed on V54 ward & Glenrothes Hospital, 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 and a HON lead will be required to assist the roll out of this CAUTI bundle.

CAUTI bundles have been implemented within 4 care homes as a trial, with the aim to roll out across all care homes, to optimise urinary catheter maintenance to all care home residents. This work is to be led by the IPC Care Home Senior IPCN for NHS Fife.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non-compliance.
- A minimum of 20 observations are required to be audited, per month, per ward.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP
- LanQIP is no longer supported by NHS eHealth and Wards are no longer submitting their Hand Hygiene. There is therefore no current electronic recording system for reporting HH compliance or an overview dashboard to monitor compliance.

5.1 Trends

- Unable to report
- ICM raising with Senior Management and D&I Teams

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 3 (Oct-Dec 2022) was **95.9%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the National Monitoring Framework for NHS Scotland National Cleaning Services Specification. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

Domestic Location	Q3 Oct-Dec 22	Q2 Jul-Sep 22
Fife	95.9↓	96.2%
Scotland	Awaiting national comparison	95.3%

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct-Dec) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 22	Q2 Jul-Sep 22
Fife	96.5↑	96.3
Scotland	Awaiting national comparison	96.4

- The Estates Monitoring – quarterly compliance report result for Quarter 3 (Oct-Dec) 23 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

· Areas with results below 90% for all Hospital & Healthcare facilities have been identified to relevant managers for action.

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7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place.

Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any) & how many days the closure lasted.

A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda.

All ward/ bay closures due to Norovirus & Influenza are reported to HPS weekly plus all closures due to an Acute Respiratory Illness (ARI).

November – end of December 2022

Norovirus

There have been 2 new ward closures due to Norovirus or suspected outbreak since last ICC report

Seasonal Influenza

There has been 3 new closures due to confirmed Influenza since the last reporting period.

Weekly national seasonal respiratory report- Week 1, **week ending 8th of January 2023**

Weekly respiratory main points

- The proportion of NHS24 calls that were for respiratory symptoms decreased from Moderate to **Baseline** activity level overall.
- The incidence rate of influenza has decreased to **Moderate** activity level overall.
- *Mycoplasma pneumoniae* and parainfluenza remained at **Baseline** activity level. Adenovirus and rhinovirus decreased from Low to **Baseline** activity level. Seasonal coronavirus (non-SARS-CoV-2) decreased from Moderate to **Baseline** activity level.
- RSV remained at **Low** activity level.
- The hospitalisation rate for influenza has been generally increasing since week 25 2022 and has seen a peak of 26.9 per 100,000 in week 51 2022 but has gradually reduced since then.

7.2 COVID-19 pandemic

COVID weekly main points

- In Scotland, in the week ending 31 December 2022, the estimated number of people testing positive for COVID-19 was 219,600 (95% credible interval: 189,300 to 251,600), equating to 4.17% of the population, or around 1 in 25 people (Source: Coronavirus (COVID-19) Infection Survey, UK - Office for National Statistics)
- In the week ending 15 January 2023, there were on average 1,147 patients in hospital with COVID-19
- In the week ending 08 January 2023, there were 81 deaths involving COVID-19 (13 more than the previous week) (Source: National Records of Scotland)

COVID-19 incidents/clusters/outbreaks November – December 2022, there has been 23 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

Hospital	Ward	Date First Reported ARHAI	Total No. Patients	Total No. HCWs	Total No. Deaths
HSCP					
Adamson	Tarvit	23/12/2022	9	1	0
Cameron	Balgonie (Balfour)	15/12/2022	5	2	0
Cameron	Balgonie	23/12/2022	4	1	1
Cameron	Letham	23/12/2022	2	1	0
Glenrothes	Ward 3	15/12/2022	2	1	0
Glenrothes	Ward 3	16/11/2022	8	1	1
QMH	Ward 8	04/11/2022	3	1	0
QMH	Ward 5	08/12/2022	4	0	0
QMH	Ward 5	19/12/2022	5	0	0
QMH	Ward 6	08/12/2022	11	2	1
QMH	Ward 6	04/11/2022	9	3	1
QMH	Ward 2	23/12/2022	5	0	0
QMH	Ward 3	15/12/2022	3	3	1
St Andrews	Ward 1	15/12/2022	8	4	1
St Andrews	Ward 2	15/12/2022	2	1	0
WMBH	Ravenscraig	24/11/2022	6	4	0
VHK					
VHK	V41	16/11/2022	2	0	0
VHK	V32	16/11/2022	4	0	0
VHK	V41	23/12/2022	3	0	0
VHK	V41	29/12/2022	3	0	0
VHK	V22	08/12/2022	4	4	0
VHK	V42	29/12/2022	3	0	0
VHK	V6	24/11/2022	10	0	1

8. Surgical Site Infection Surveillance Programme

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

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been postponed, and we are currently awaiting further instruction.

8 a) Caesarean section SSI

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

8 b) Hip Arthroplasty SSI

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

8 c) Hemi arthroplasty SSI

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

8 d) Knees SSI

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

8 e) Large Bowel SSI

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

9. Hospital Inspection Team

There have been no inspections during this reporting period

10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has improved in 2022, compared to 2021. However, the cumulative total of HCAIs is slightly higher, and thus, 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
- **SSIs surveillance** currently suspended during COVID pandemic for C-sections, Large bowel surgery and Orthopaedic procedure surgeries (Total hip replacements, Knee replacements & Repair fractured neck of femurs). Awaiting further instruction regarding resumption of surveillance. Increased resources and months of preparing will be required prior to recommencing.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are 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

Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI / UnKnown	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Apr-22	5	2	7	2	2	4	8	15	23
May-22	3	5	8	3	2	5	12	10	22
Jun-22	5	3	8	3	0	3	15	10	25
Jul-22	6	3	9	4	1	5	13	14	27
Aug-22	3	5	8	3	1	4	10	15	25
Sep-22	5	2	7	2	0	2	10	15	25
Oct-22	3	4	7	1	0	1	13	12	25
Nov-22	6	3	9	3	0	3	8	10	18
Dec-22	1	5	6	4	2	6	7	14	21

Cleaning Compliance (%) TOTAL FIFE												
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Overall	96.1	96.4	96.1	96.2	95.9	95.8	96.4	96.3	96.1	95.6	96.2	96.2

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

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	2	1	2
May-22	2	2	8
Jun-22	2	1	5
Jul-22	1	1	3
Aug-22	2	0	2
Sep-22	2	0	2
Oct-22	2	0	3
Nov-22	4	2	4
Dec-22	0	2	3

Cleaning Compliance (%) Victoria Hospital												
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Overall	95.2	96.2	96.0	95.9	95.7	95.9	95.7	96.5	95.9	95.6	95.6	96.3

Estates Monitoring Compliance (%) Victoria Hospital												
	Jan 22	Feb 22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22
Overall	96.3	98.0	98.0	97.4	97.2	97.0	96.8	97.4	97.1	97.1	97.6	97.2

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	1	0
Jun-22	0	0	0
Jul-22	2	0	0
Aug-22	0	1	0
Sep-22	2	0	1
Oct-22	0	0	3
Nov-22	0	0	0
Dec-22	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec
Overall	97.5	97.8	96.0	97.2	97.1	96.4	97.6	96.5	96.3	95.8	96.4	96.3

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Overall	96.4	96.5	96.6	96.0	95.4	96.6	95.5	95.9	95.4	96.6	95.9	96.6

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	0	0
Jun-22	0	0	0
Jul-22	0	0	0
Aug-22	0	1	0
Sep-22	0	1	0
Oct-22	1	0	0
Nov-22	0	0	0
Dec-22	0	0	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-22	3	2	1	2	6	15
May-22	1	5	0	2	4	10
Jun-22	3	3	2	0	10	10
Jul-22	3	3	3	1	10	14
Aug-22	1	5	1	1	8	15
Sep-22	1	2	1	0	7	15
Oct-22	0	4	1	0	7	12
Nov-22	2	3	1	0	4	10
Dec-22	1	5	2	2	4	14

Appendix 1 References and Links

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

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

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

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

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

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

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

HPS Linkage Origin Definitions

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

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

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**NHS Fife Response to the Ockenden Report**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Anne MacKinnon, Quality Improvement Midwife, Aileen Lawrie, Associate Director of Midwifery, Dr Nithiya Palaniappan, Consultant Obstetrician & Gynaecologist**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Discussion
- Assurance

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides a review of the learning from the Ockenden review report (NHS England) and indentifies recommendations for NHS Fife's maternity services to ensure safe and effective person centred care.

2.2 Background

In 2017 the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust Initially the review comprised of 23 families however, following publicity of this review, there was a final total of 1486 families involved.

The purpose of the review was to determine, as far as was reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to maternal deaths, stillbirths, neonatal deaths and babies diagnosed with Grade 2 and 3 hypoxic ischemic encephalopathy.

The final Ockenden Report - *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust* – was published on 30 March 2022. It particularly focused on the Trust's failings in governance processes which directly led to the harm experienced by families, as well as failures in clinical care.

The report raised 15 areas for "immediate and essential action" to improve care and safety in maternity services across NHS England. With acknowledgment that healthcare is devolved there remains a requirement to learn from independent reviews and to benchmark our own service against recommendations

2.3 Assessment

While considering the recommendations from the report it must be recognised that there are key differences in maternity services, and in the systems for providing assurance around the safety and effectiveness of NHS service between Scotland and England.

A benchmarking exercise involving a multidisciplinary team was undertaken within NHS Fife Maternity services to consider the 15 broad immediate essential actions listed under the key themes below as recommended in the report.

1. Workforce Planning and Sustainability
2. Safe Staffing
3. Escalation and Accountability
4. Clinical Governance and Leadership
5. Clinical Governance – Incident Investigation and Complaints
6. Learning from Maternal Deaths
7. Multidisciplinary Training
8. Complex Antenatal Care
9. Preterm Birth
10. Labour and Birth
11. Obstetric Anaesthesia
12. Postnatal Care
13. Bereavement Care
14. Neonatal Care
15. Supporting Families

Within the 15 immediate action there were eighty-nine separate recommendations for consideration

RAG status was applied to determine any local actions that were required (Full analysis in Appendix 1)

SUMMARY OF KEY FINDINGS
Seven of the eighty-nine recommendations were not applicable within the Scottish Healthcare structure as they involved reporting to specific commissioning bodies within NHS England Healthcare systems. Seventy-eight of the recommendations were rated as **green**; four recommendations were rated **amber**. It should be noted that maintaining green RAG and improving amber/red RAG is dependent on achieving and maintaining safe staffing levels. The key areas for improvement (amber rating) are summarised below:
WORKFORCE PLANNING AND SUSTAINABILITY
Recommendation: Minimum staffing levels are agreed nationally or if there is no national agreement a local agreement should be reached.
Work is underway nationally with Healthcare Improvement Scotland leading a package of work to prioritise the midwifery workload and workforce planning tools. NHS Fife maternity unit is a pilot site for testing the real time staff workforce tool. NHS Fife are working toward implementation of the Health and Care (Staffing) (Scotland) Act 2019. Work is ongoing locally to review consultant job plans.
CLINICAL GOVERNANCE-LEADERSHIP
Recommendation: Boards to ensure they have a patient safety specialist who is specifically dedicated to maternity services
Within the maternity service there are dedicated Clinical Risk Midwives to oversee clinical incidents LAER's and SAER's management. An equivalent role is required within neonatal services.
Recommendation: All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities
Consultant job planning in progress
MULTIDISCIPLINARY TRAINING
Recommendation: Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory
This has been identified as Core Mandatory training for the midwifery workforce outlined by the CMO with reporting requirements to Scottish Government. Face to face training is provided through PROMPT, NLS, and K2 Fetal monitoring training package, with plans to reinstate face to face CTG training for all staff. There is no mandatory requirement for medical staff to complete the same core set of learning.

2.3.1 Quality / Patient Care

Quality of care reviewed within the benchmarking exercise

2.3.2 Workforce

It should be noted that maintaining green RAG and improving amber/red RAG is dependent on achieving and maintaining safe staffing levels.

2.3.3 Financial

Funding to be identified to support the implementation of a clinical risk role for neonates and paediatrics

2.3.4 Risk Assessment / Management

Actions detailed in report

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

No impact

2.3.6 Climate Emergency & Sustainability Impact

No impact

2.3.7 Communication, involvement, engagement and consultation

Relevant stakeholders involved in the review

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 supported the content

- Women & Children's Ockenden Review Short Life Working Group
- Women & Children's Maternity Clinical Governance Sub- Group
- Women & Children's Clinical Governance Group
- Acute Services Clinical Governance Group 16/11/2022
- Executive Directors Group 16/02/2023

2.4 Recommendation

Workforce planning and sustainability is being managed via both local and National processes. There is a requirement for the development of a clinical risk role for neonatology and paediatrics and the concomitant finance that will be required to support this role. The discussion regarding mandatory training to include medical staff is required at a national level.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, RAG Status

Report Contact

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Appendix 1

The Ockenden report raised 15 areas for “immediate and essential action” to improve care and safety in maternity services across England.

	1.WORKFORCE PLANNING AND SUSTAINABILITY		
	Essential Actions	**NHS Fife Review and Response**	**RAG Status**
1	Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational requirements	**Midwifery** • Real time workforce tool for midwifery safe staffing • Digital version will be available by February 2023 • Workforce tool will run again in November • Minimum midwifery staffing levels to be agreed nationally • Working toward implementation of the Health and Care staffing legislation **Medical** • Consultant obstetric job plans being reviewed	
2	Implement a robust preceptorship programme for newly qualified midwives (NQMs), which supports supernumerary status during their orientation period and protected learning time for professional development	• Flying Start programme in place • NQM support network • Orientation programme in place Blink (joinblink.com)	
3	NQMs must remain within the hospital setting for a minimum period of one year post qualification.	• Able to support this currently	
4	Ensure all midwives responsible for coordinating a labour ward attend a fully funded and nationally recognised labour ward co-coordinator education module.	• RCM Labour Ward Coordinators Workshop • Review Labour Ward coordinator job description and training – no national agreed coordinators education programme or job description	
5	Ensure newly appointed labour ward coordinators receive an orientation package that reflects their individual needs.	• Support system and wide orientation programme in place	

	Essential Actions	NHS Fife Review and Response	RAG Status
6	Develop a core team of senior midwives who are trained in the provision of high-dependency maternity care. The core team should be large enough to ensure there is at least one high-dependency unit-trained midwife on each shift 24/7.	Adult critical care service available and will be utilised for all women requiring high dependency care • Care of the Critically ill women (PROMPT) • Critically Ill Obstetric guideline and pathway  • Critically Ill Ob	
7	Develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers	• Leaderships development programmes locally and nationally through local Practice development department. • National leadership programmes through National Education for Scotland (NES) such as Scottish Improvement Leadership (ScIL) and Scottish Coaching and Leadership programme (SCLIP) • Support to undertake Master's Degrees	

2. SAFE STAFFING			
Essential Actions		**NHS Fife Review and Response**	**RAG Status**
8	Maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	• Maternity Escalation Plan Escalation Gui	
9	Ensure the labour ward co-coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	• Reviewing job description • No national job description	
10	All trusts must review and suspend if necessary the existing provision and further roll-out of midwifery continuity of carer model(MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts	• BEST Start Recommendations remain in place nationally	
11	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	• Study leave allowance protected • SPA sessions are protected	
12	Ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	• Dedicated Midwifery Educator in place • PROMPT and NLS delivered in clinical environment	
13	Newly appointed Band 7 or 8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	• Induction process in place	
14	Develop strategies to maintain bidirectional robust pathways between midwifery staff in the community setting and those based in the hospital setting to ensure high-quality care and communication	• Badgernet access • Clinical guideline and pathways • EPR access multidisciplinary	
15	Follow the latest RCOG guidance on management of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	• RCOG Guidance followed	

3. Escalation and accountability			
Essential Actions		**NHS Fife Review and Response**	**RAG Status**
16	Staff must be able to escalate concerns if necessary	• NHS Fife Escalation Guideline for Maternity • NHS Scotland Whistleblowing Policy • Incident Reporting	
17	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times	• Real time workforce tool for midwifery safe staffing • Training and education programmes	
18	If not resident there must be clear guidelines for when a consultant obstetrician should attend	• Guidance for when a consultant attends in line with RCOG	
19	Develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	• Escalation to Clinical Lead • Escalation to Midwifery Managers • Escalation to SCM	
20	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence, trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	• Educational and training mentors	
21	Aim to increase resident consultant obstetrician presence where this is achievable.	•	N/A
22	Must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	• Guidance for when a consultant attends in line with RCOG	
23	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on call should be informed of activity within the unit.	• Maternity Escalation Plan	

4: CLINICAL GOVERNANCE-LEADERSHIP			
Essential Actions		**NHS Fife Review and Response**	**RAG Status**
24	Boards must have oversight of the quality and performance of their maternity services	• Clinical Governance Specialty Subgroups, • Women & Children's Clinical Governance Group, • Acute Services Clinical Governance Group, • Women & Children's Clinical Governance Framework  Women ar	
25	In all maternity services, the director of midwifery and clinical director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	• Associate Director of Midwifery / Clinical Director	
26	Boards must work together with maternity departments to develop regular progress and exception reports and assurance reviews, and regularly review the progress of any maternity improvement and transformation plans.	• Reporting through the Acute Service Clinical Governance Group and Performance Management group • Standard Reporting template  • Template [	
27	All maternity service senior leadership teams must use appreciative inquiry to complete the national maternity self-assessment tool if not previously done.	• NHS England self assessment	N/A
28	Boards to ensure they have a patient safety specialist who is specifically dedicated to maternity services.	• No specific board safety specialist • Clinical Risk Midwife(s) • NHS Fife Adverse Events Team • Neonatal Clinical Risk Nurse required	
29	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	• Medical job plans under review – to include dedicated time for clinical governance activity	

	Essential Actions	NHS Fife Review and Response	RAG Status
30	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	• TURAS / RCM Modules • Shadowing	
31	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda, and have links with audit and research.	• Guideline group co- chaired by Consultant Obstetrician and Quality Improvement Midwife (Band 8a)  Guideline Gu	
32	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	• Consultant Obstetrician and Midwife Quality Improvement Midwife (Band 8a) • Audits recorded on the NHS Fife Clinical Effectiveness Register	

5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS			
	Essential Actions	**NHS Fife Review and Response**	**RAG Status**
33	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families	• Redacted full report – offer of meeting to discuss the report, follow up letter following meeting followed.	
34	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	• Themes of the month from incident reviews shared with clinical teams to inform mandatory and local multidisciplinary training (PROMPT, Skills and Drills within department) • CTG case discussions at Medical Midwifery Meetings	
35	Actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred.	• Action from incidents recorded on Datix and reviewed at Maternal and Perinatal mortality and morbidity group meetings.	

	Essential Actions	NHS Fife Review and Response	RAG Status
36	Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred.	• Action from incidents recorded on Datix and reviewed at Maternal and Perinatal mortality and morbidity group meetings.	
37	All trusts must ensure that complaints that meet the serious incident threshold must be investigated as such.	• NHS Fife Complaint process followed	
38	All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent.	• No Maternity Voices Partnership in Scotland • Following NHS Fife process	
39	Complaints' themes and trends must be monitored by the maternity governance team.	• Included in Clinical Governance and Performance Management Reports	

6: LEARNING FROM MATERNAL DEATHS			
	Essential Actions	NHS Fife Review and Response	RAG Status
40	Nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings, must have an independent chair	• NHS Fife Adverse Event Process and National Maternal and neonatal adverse event process followed for all maternal deaths • All maternal deaths reported to MBRRACE	

7: MULTIDISCIPLINARY TRAINING			
	Essential Actions	NHS Fife Review and Response	RAG Status
41	41All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	• PROMPT /NLS – mandatory Scottish Government training requirement • Attendance at training recorded and compliance monitored. • Challenges with meeting this target given workforce challenges	
42	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	• SBAR handovers included in PROMPT training	

	Essential Actions	NHS Fife Review and Response	RAG Status
43	All trusts must mandate annual human factor training for all staff working in a maternity setting. This should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concern	• Not mandated – included in PROMPT • Resources available • TURAS Human Factors Module • MCQIC Safety Culture Webinar Series • K2 Human Factors Module • Equality and Diversity is mandated • RCM Human Factors models	
44	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies, including haemorrhage, hypertension and cardiac arrest, and the deteriorating patient.	• In place delivered through the following training - K2, PROMPT, skills and drills training mandatory for all staff	
45	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well-supported staff teams are better able to consistently deliver kind and compassionate care.	• Clinical Supervision for Midwives, Perinatal Mental Health Team , OHSAS, NHS Fife Peer Support , NHS Fife Chaplin • NHS Fife psychology team	
46	Systems must be in place in all trusts to ensure that all staff is trained and up to date in CTG and emergency skills.	• K2(CTG trainng) and PROMPT mandatory for all midwives compliance monitored	
47	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	• Midwifery training in place • Updating on medical training	

8: COMPLEX ANTENATAL CARE			
	Essential Actions	NHS Fife Review and Response	RAG Status
48	Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care	• No national maternal medicine network • Processes are in place	
49	Trusts must provide services for women with multiple pregnancies in line with national guidance.	• Dedicated service provided by the Fetal Medicine Team	
50	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.	• Dedicated services provided by Diabetic team in the Diabetic clinic • Hypertension clinic. • Home BP monitoring service in place	

	Essential Actions	NHS Fife Review and Response	RAG Status
51	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	• Process in place	
52	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and specialist midwifery staffing.	• Antenatal referral pathways to specialist consultant / clinics • Dedicated obstetric team • Insufficient numbers to support dedicated midwifery team • Venerable In Pregnancy (VIP) Midwifery Team , Perinatal Mental and Family Health teams support in place • Antenatal F	
53	NICE guideline (NG3) on diabetes in pregnancy (2020) should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	• NICE and SIGN guidance followed • Diabetes	
54	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	• Management plans documented on Badgernet and are accessible to women	

	Essential Actions	NHS Fife Review and Response	RAG Status
55	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate, and discuss risks and benefits to treatment. Women must be commenced on aspirin 75 to 150mg daily from 12 weeks gestation in accordance with the NICE guideline (NG133) on hypertension in pregnancy (2019).	• Antenatal referral pathways to specialist consultants / clinics • Guidelines and pathways in place for women requiring Aspirin in pregnancy • Hypertension clinic • Links with Renal team • Home BP monitoring service  • HYPERTENS  • ASPIRIN use	

9: PRETERM BIRTH			
	Essential Actions	**NHS Fife Review and Response**	**RAG Status**
56	Senior clinicians must be involved in counseling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	• Perinatal Management of extreme preterm births : Framework for Practice • Fetal Medicine Team  • Perinata	
57	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	• Perinatal Management of extreme preterm births : Framework for Practice , Fetal Medicine Team	

	Essential Actions	NHS Fife Review and Response	RAG Status
58	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival, and are aware of the risks of possible associated disability.	• Local guidance in place • National process in place • Scottish Perinatal Network currently reviewing in- utero transfer process across Scotland  • In Utero Trans  • Information	
59	There must be a continuous audit process to review all in-utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and, when delivery subsequently occurs, in the local unit.	• National audit process in place to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit	

10: LABOUR AND BIRTH			
	Essential Actions	NHS Fife Review and Response	RAG Status
60	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary	• Birth at Home Guidelines	
61	Centralised CTG-monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.		NA

	Essential Actions	NHS Fife Review and Response	RAG Status
62	All women must undergo a full clinical assessment when presenting in early or established labour.	• Labour Assessment completed on Badgernet • Intrapartum Care Guideline  • Intrapartum	
63	Midwifery-led units must: • complete yearly operational risk assessments • undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	• Action applicable to stand alone MLU • Alongside Midwife Led Unit only in NHS Fife	NA
64	Maternity units must have pathways for induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	• Dedicated IOL suite and team in place Pathways incorporated into IOL Guideline  • Induction of L	

11: OBSTETRIC ANAESTHESIA			
	Essential Actions	NHS Fife Review and Response	RAG Status
65	Essential action In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm	• Routine In-Patient follow up occurs daily by on call team • Outpatient follow up available in anaesthetic clinic	
66	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	• No current issues with staffing	

	Essential Actions	NHS Fife Review and Response	RAG Status
67	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events	• Documentation on obstetric specific anaesthetic charts and Badgernet.	
68	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience, and reduce the risk of long-term psychological consequence	• Routine In-Patient follow up occurs daily by on call team • Outpatient follow up available in anaesthetic clinic	
69	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core data sets and what constitutes a satisfactory anaesthetic record in order to maximize national engagement and compliance.	• Currently no national data set	N/A
70	Obstetric anaesthesia staffing guidance to include: • the role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services while allowing for staff leave • the full range of obstetric anaesthesia workload including elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training and governance activity • the competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments	• Guidance states that clinicians should maintain their competence if covering OOH. Sessions with regular obstetric anaesthetists are available for refreshers and obstetric anaesthesia is a regular part of our CPD educational sessions and clinical governance. • There is some guidance in 2013 OAA/RCOA Guidelines on provisions of anaesthetic services that we adhere to. Any further national guidance would be welcomed to support further staffing • Participation in war rounds	
71	Participation by anaesthetists in the maternity multidisciplinary ward rounds, as recommended in the first report	• Not routinely due to limits on staffing due to combined elective and emergency work. If the majority of scheduled CS were to happen on dedicated theatre lists this would free up the consultant to attend the ward round • Although the bi-daily MDT handovers could be viewed as a ward round and contribute to situational awareness	

12: POSTNATAL CARE			
Essential Actions		**NHS Fife Review and Response**	**RAG Status**
72	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward, both day and night, for both mothers and babies.	• National real time staffing workforce tool piloted • Daily reviews of staffing level in all departments	
73	All trusts must develop a system to ensure consultant review of all postnatal readmissions and unwell postnatal women, including those requiring care on a non- maternity ward.	• Systems in place for identifying deteriorating patients such as MEWS , SEPSIS Six ,twice daily consultant ward round , labour ward coordinator “helicopter” overviews, Readmission reported on Datix and reviewed	

13. BEREAVEMENT CARE			
Essential Actions		**NHS Fife Review and Response**	**RAG Status**
74	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	• Implementing the National Bereavement pathway (early implementer) • Dedicated Bereavement Nurse • Midwife champions • National Bereavement Pathway • Psychology Team • Birth Trauma Training • Chaplaincy Services available 24/7 • Stillbirth and Neonatal Death guideline •  Stillbirth Guic •  Neonatal D	

	Essential Actions	NHS Fife Review and Response	RAG Status
75	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement, and in the purpose and procedures of post-mortem examinations.	• Post-mortem consent undertaken by consultant obstetricians	
76	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcomes.	• Follow up postnatal debrief clinics with consultants in place	
77	Compassionate, individualized and high-quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	• Implementing the National Bereavement pathway • Dedicated Bereavement Nurse • Midwife champions • National Bereavement Pathway • Psychology Team • Birth Trauma Training • Chaplaincy Services available 24/7	

14: NEONATAL CARE			
	Essential Actions	**NHS Fife Review and Response**	**RAG Status**
78	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	• Best Start/Scottish Perinatal network • Local In- utero transfer guidance in place • National guidance in development by the Scottish Perinatal Network	
79	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly		N/A
80	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU	• Best Start Pilot site – in-utero transfer out for all babies less than 27 weeks gestation	

Essential Actions		NHS Fife Review and Response	RAG Status
81	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation	• No national process in place to facilitate	N/A
82	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation	• No commissioning system in Scotland	N/A
83	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required	• Consultant not on site can be contacted via switchboard	
84	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications	• In place	

15: SUPPORTING FAMILIES			
	Essential Actions	**NHS Fife Review and Response**	**RAG Status**
85	Maternity care providers must actively engage with the local community and those with lived experience to deliver services that are informed by what women and their families say they need from their care.	• MUSA Service Users • SANDS • Care Opinion • Questionnaires (Maternity ward /MLU) • Consultation regarding services changes • NHS Fife Pregnancy and Birth Facebook	
86	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	• Perinatal Mental Health Team • Perinatal Mental Health Midwife , • Perinatal Mental Health Pathway in place • VIP Team , Family Health , • Postnatal Debrief , • Named contact for SAER (Community Midwife •  Perinatal Me •  Community Pe	
87	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications	• In place	
88	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences	• Dedicated Psychology team available for supporting parents	
89	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	• As above	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**National Treatment Centre – Fife Orthopaedics: Status Update / NHS Assure Impact**
Responsible Executive:	**Janette Keenan – Director of Nursing**
Report Author:	**Ben Johnston – Head of Capital Planning / Project Director**

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Assurance

This report relates to:

- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to provide an update on the current position regarding the National Treatment Centre for Fife and particularly in respect to the opening of the centre following receipt of DL (2023) 03.

2.2 Background

The project involves providing a new National Treatment Centre for Orthopaedics at the Victoria Hospital in Kirkcaldy. The accommodation generally comprises of 3 theatres together with in-patient and outpatient accommodation. The Gross Internal Floor Area is currently 6,142m2 and the forecast project cost is currently £33.44m.

The Full Business Case was approved by the Board in November 2020 and then by the Scottish Capital Investment Group on 11 March 2021, allowing the construction phase of the project to commence. Following the completion of car par enabling works, the project

started on site on 1 March 2021 and was due for completion in January 2023 with a “go live” date planned for end February / beginning March 2023. A project Handover Meeting occurred on 30 January 2023 and at that point the team were hopeful that the building could be put into use at the end of February 2023.

DL (2023) 03 was received on 6 February 2023, which states that a building cannot be used until it receives “supported status” from NHS Assure.

The NHS Assure Key Stage Assurance Review (KSAR) service forms part of National Services Scotland and has been formed to provide assurance around technical compliance for major new-builds and refurbishments in the Scottish health sector.

2.3 Assessment

The timing of DL (2023) 03 together with the maturity of the NHS Assure KSAR service has challenged our planned completion activities for the project.

The NHS Assure KSAR Commissioning Workbook was issued to NHS Fife on 6 October 2022 whilst NHS Fife’s commissioning activities commenced in July 2022. The NHS Assure Handover Workbook was received on 24 January 2023 a few days before we were due to complete the construction phase of the project (30 January 2023). The timing of these new documents/processes and the effort required to respond to the criteria has been challenging for the Project Team to manage in parallel with completing the build. Indeed, NHS Fife are the first Health Board in Scotland to undertake a Commissioning and Handover KSAR.

Given the foregoing the Project Board met to consider the potential impacts of the NHS Assure process on the go live date. Taking cognisance of the DL, following discussion and debate the recommendation was to move the go live date to 20 March 2023 and this has since been approved.

Following ongoing dialogue with NHS Assure from 16 January 2023, NHS Fife issued the completed Commissioning and Handover KSAR workbooks to NHS Assure on 13 February 2023. NHS Assure have since issued their KSAR Commissioning Stage Detailed Review Findings (DRF’s) and NHS Fife responded to these on 22 February 2023 with an ongoing commitment to review/close out any remaining residual items. The table below provides a summary of the items DRF’s.

NTC Fife - KSAR Commissioning Stage Detailed Review Findings *Cat 1 = most significant* *Cat 4 = least significant*						
	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Water / drainage	2	9	20	9	4	44
Electrical	5	12	6	0	0	23
Medical gas	0	2	2	1	0	5
Ventilation	0	14	6	3	1	24
Fire	1	0	1	4	2	8
Infection control	0	4	2	1	0	7
Governance	No DRF provided					
Total	8	41	37	18	7	111

The Project Team have responded to the points noted in the table. To provide assurance around the items deemed most significant by NHS Assure we would summarise the status (at 24.02.23) as follows:

- Water and drainage – all items dealt with, no concerns
- Electrical – some residual items to be closed in respect to paperwork only (updated electrical certificate and risk assessments). General agreement in respect to actions and status, no concerns
- Fire – remedial work undertaken to deal with concern noted (door closers on bedroom half leaf doors)

We have held Technical Workshops with NHS Assure concerning water/drainage and power (electrical). A workshop in respect to ventilation is scheduled for 27 February 2023. It is considered that this should then pave the way for all key items to be discharged with agreement to close out any other remaining points thereafter.

To date we have not collectively identified any “show-stopper” issues which would require either significant re-design or construction components.

In parallel with the technical effort connected to dealing with this process, NHS Fife are working closely with SG, NSS and NHS Assure at a senior level with a view to receiving supported status as soon as is practicably possible.

2.3.1 Quality / Patient Care

Covered within paper

2.3.2 Workforce

Not used

2.3.3 Financial

There is significant effort required to engage with the NHS Assure KSAR process. This requires additional resource which is out with the scope of the contract. We are however satisfied that this can be contained within the current project budget.

2.3.4 Risk Assessment / Management

There is a residual risk that we are not able to obtain NHS Assure supported status to facilitate the new go live date of 20 March 2023. With everyone pulling in the same direction, we hope that this risk is low, however it remains a key risk for the Project and Board meantime.

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

Not used

2.3.6 Climate Emergency & Sustainability Impact

Not used

2.3.7 Communication, involvement, engagement and consultation

No communications have been released by our communications team in respect to the opening date. This will remain the case until there is more certainty around NHS Assure KSAR status. Our communications team are also working closely with Scottish Government to ensure there is a coordinated plan in this regard.

2.3.8 Route to the Meeting

- Executive Director's Group, 16 February 2023
- Clinical Governance Committee, 3 March 2023
- Finance, Performance & Resources Committee, 14 March 2023

2.4 Recommendation

This paper is being provided to member for:

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

3 List of appendices

- NA

Report Contact
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Information Governance and Security Steering Group Update**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy - SIRO**
Report Author:	**Alistair Graham – Associate Director of Digital & Information**

1 Purpose

This is presented 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 report is the second report for the financial year 2022-23, with the previous report provided to the September 2022 meeting of Clinical Governance Committee.

The Steering Group continue to support the tasks, activities and projects that are key to the continuous improvement, mitigation of risk and evidence of improved controls for the areas of IG&S.

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.

The report is intended to provide **assurance** to the Committee

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 in January 2023 compared to October 2022 is presented below: -

Categorisation	Total Risks October 2022	October 2022 Risk Level Breakdown	Total Risks January 2023	January 2023 Risk Level Breakdown
DPA and GDPR Risk that data maybe lost, used inappropriately, or retained for longer than necessary	15	High Risk – 3 Moderate Risk – 10 Low Risk - 2	13	High Risk – 2 Moderate Risk – 9 Low Risk - 2
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	2	High Risk – 0 Moderate Risk – 2 Low Risk - 0	2	High Risk – 0 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	11	High Risk – 6 Moderate Risk – 4 Low Risk – 1	11	High Risk – 6 Moderate Risk – 4 Low Risk – 1

Key Priorities

The presentation of the Activity Tracker and Assurance measures continues to be a focus for the Steering group. 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 – Postponed from August 2022 till March 2023.
- 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 Steering group continue to use these measures to adapt their approach within priority areas to ensure improved performance.

2.3 Assessment

Through the establishment of control and reporting mechanisms in the previous year 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)

The SAR Short Life Working Group (SLWG) has completed its work on reviewing existing approach for SAR activity and moves to implement a revised set of processes. Performance across areas remains variable as highlighted in Appendix 1 and with the introduction of a revised system of recording performance being implemented improved reporting is expected to be evident in April 2023.

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 requests for new technologies and meet 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.

The rewrite of NHS Fife's Digital Solutions Procurement Policy is ongoing, with a draft being presented to the Procurement Governance Oversight Group at their meeting on 22 February 2023. Further definition of supporting process will follow once the Procurement Oversight Group have had the opportunity to comment.

The Policy is expected to be presented for sign off in April 2023.

Planned improvement to Information Asset Register and associated Service Catalogue

Work continues to catalogue all information assets in use within NHS Fife, including those that have been mandated nationally. While rapid risk assessment was allowed during the initial period of the pandemic, the appropriate identification of Information Asset owners is necessary to support this work.

Plans for its population across all NHS Fife Information Assets will progress for the remainder of 2022-23, with the approach initially adopted under review, following feedback received from Directors and Services' Senior Management. The establishment of the register will also allow cataloguing of existing contractual arrangements and associated supplier management expectations.

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

As reported to Clinical Governance Committee in January 2023, the response to NHS Fife's Records Management Plan, has been received from the Keeper. While all 15 areas of the plan are being progressed, focus is being given to the two Amber areas of Business Classification and Audit trail.

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 improvement 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.

The 21 associated procedures have been reviewed and will be presented to the Policies and Procedures group for consideration.

NISD Action Plan Implementation
The NISD Audit Report (May 2022), reported a compliance level of 76% and increase from the previous year of 69%.

The associated action plan 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 postponed their intended audit in October 2022 and new dates in March 2023 (16,17 and 20 March) have been confirmed.

This audit is consistent with many other areas of NHS Scotland.

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 with a report by the end of April 2023.

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

Additional Assurance Mapping

At their October 2022 meeting, the Steering Group reviewed a mapping of measures and controls associated with the ICO Accountability Framework, NISD and Cyber Resilience Framework along with additional requirement for Records Management.

The assurance mapping worked identified several common elements to the two Frameworks, just a difference in language. The items that would be unified in presentation included:-

- Leadership and Oversight and Organisational Governance, including Risk
- Policies and Procedure and Risk Management, Information Security Management, Supplier Management, Operational Security and Supplier Management
- Training and Awareness and People
- Contracts and data sharing and Supplier Management
- Risks and DPIAs and Risk Management, Business Continuity and Security Management
- Business Continuity and Recovery and Backup
- Breach Response and monitoring and Incident Management/Detection, Operational and Network Security

This new framework intends to be established for the April 2023 steering group meeting

Incident Reporting

During the period September 2022 to January 2023, 5 incidents were reported to the ICO and/or NISD Competent Authority, bringing the total for the financial year 2022-23 to 12. All 5 incidents were reported within the required 72-hour period.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

No other impact considered.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

- Executive Directors Group – 16 February 2023

2.4 Recommendation

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

3 List of appendices

Appendix 1 – IG&S Operational Performance

Report Contact

Alistair Graham
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Appendix 1 – IG&S Operational Performance

	Information Governance & Security Performance Summary	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Operational Performance	Cyber Security - Exposure Score*	25%	38	26	24	25	23	20	26	24	23	22	29	25	
	FOI's - Responses within target	85%	80.8%	90.8%	90.3%	97.6%	96.0%	90.5%	80.0%	83.1%	86.3%	93.8%	95.0%	89.9%	
	SARs Received (% responded to timeously)	100%	96.0%	100.0%	97.0%	67.0%	87.0%	84.0%	100.0%	100.0%	97.7%	98.0%	98.9%	99.0%	
	Information Governance Incidents	Avg 98	120	129	98	97	128	98	85	102	90	78	82	68	
	Incidents Reported to ICO or CA		1	1	0	0	2	1	1	3	2	1	0	0	
	Incidents Reported within 72 Hours		1	0	0	0	1	1	1	3	2	1	0	0	
	Follow up required by ICO		0	0	0	0	1 x TBC	0	0	1 x TBC	1 x TBC	1 x TBC	0	0	
	Annual Measures		2020	2021	2022										
	NISD Compliance Status		53%	69%	76%										
	NISD Risk Exposure		13%	8%	3%										
	NISD Controls Completed		53%	58%	64%										

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This 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 monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 50% by 31st March 2023)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure

that the quality of patient experience is described, and to improve the complaint handling performance in line with national standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
  - Shadowing / observation
  - Walkarounds
  - 15 step challenge

IMPROVING THE EXPERIENCE
It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
  - Framework
  - Leadership
  - Education and training
- Engage staff, patients, families, and carers in improvement work

2.3 Assessment

On reviewing the stage 2 complaints, an improving position remains evident. Weekly Summary data collection commenced in August 2022, and 192 stage 2 complaints have now reduced to 148 (23% reduction). There is now a level of detail that clarifies where each complaint is in the process, and additional data will include the number of stage 2 complaints received weekly.

STAGE 2	17/10/2022		21/11/2022		19/12/2022	
Total	**143**	%	**143**	%	**148**	%
Awaiting Statements	63	44	72	50	71	48
Returned to Service insufficient statement	0	0	1	1	1	1
Requires PRD Action	15	10	12	8	12	8
Ready to draft	5	3	7	5	2	1
Drafting in Progress	1	1	3	2	3	2
FR out for comment	17	12	9	6	11	7
FR out for approval	37	26	34	24	43	29
FR with Director H&SCP	1	1	1	1	2	1
FR with GM for sign off	0	0	1	1	0	0
FR with Head of Service for sign off	3	2	1	1	3	2
FR sent to CEO	1	1	2	1	0	0
Signed Final Response			7		11	

During this period we have been able to demonstrate almost 50% of stage 2 complaints are subject to a delay in receiving statements, with a further 40% awaiting comments or approval from services.

As of 13 December 2022, there were 148 stage 2 complaints however, only 18 were within the 20-day target. Out of those 18, none had statement returned within the agreed target; therefore predicted compliance the national 20-day target remains extremely low.

Performance (against the measure of all complaints closed in the month) improved slightly in November 2022 (6.7%). As any development in processes of handling new complaints would not be demonstrated in this metric due to the closure of any of the backlog of outstanding complaints, an additional metric has been incorporated based on receipt of new complaints and whether they are closed within the 20-day response target.

The provisional response rate for November is 56.7%; a final figure will be available at the end of December after 20 working days beyond 30 November have elapsed. Moving forward, both metrics will be presented within the IPQR.

The number of Stage 2 complaints closed in November 2022 was 30. Process mapping, feedback, and discussions will continue to take place over the next quarter to investigate issues with delays in receiving statements within the agreed local 10-day target.

A Recovery and Improvement Plan (Appendix 1) has been developed to guide the redesign of the Patient Experience service, focusing on patient experience and feedback.

The development of a quarterly report for the Clinical Governance Committee captures information on 'Measuring the Experience' and 'Improving the Experience'.

The report provides information on different methods of gathering feedback. As we emerge from the pandemic, we will report on any work taken forward to understand and improve the patient experience.

The report also captures performance data required as part of the Model Complaints Handling Procedure.

In line with the Organisational Learning Group, future reports will highlight emerging themes, lessons learned, and quality improvement initiatives.

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 was rebranded to the Patient Experience Team (PET) and the launch of this commenced 19 December 2022. The Patient Relations Team will be referred to as the Patient Experience Team within this document.

Current Establishment:

Head of Patient Experience	Band 8a	Permanent	1.0 WTE
PET Leader	Band 7	Permanent	1.0 WTE
PET Officers	Band 6	Permanent	3.4 WTE
PET Support Officers	Band 4	Permanent	1.8 WTE
PET Administrators	Band 3	Permanent	2.07 WTE

Additional team support consists of**:**

PET Officers (in post)	Band 6	Bank	1.0WTE
PET Officers (starting Jan 2023)	Band 6	6-month Fixed Term	1.0WTE
PET Officers (interview Jan 2023)	Band 6	6-month Fixed Term	1.0WTE
PET Support Officer (in post)	Band 4	9-month Fixed Term	0.69 WTE
PET Administrator/ Navigator (Shortlisting)	Band 4	9-month Fixed Term	1.0 WTE
PET Feedback Administrator (commence post Jan 2023)	Band 4	Bank	0.26 WTE

2.3.3 Financial

n/a

2.3.4 Risk Assessment/Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk.

2.3.5 Equality and Diversity, including health inequalities

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People‘s rights are respected, protected and fulfilled
- Providers of care clearly inform people of their rights and entitlements
- People are supported to be fully involved in decisions that affect them
- Providers of care and support respect, protect and fulfil people‘s rights and are accountable for doing this
- People do not experience discrimination in any form
- People are clear about how they can seek redress if they believe their rights are being infringed or denied

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team
Executive Directors Group 16 February 2023

2.4 Recommendation

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

3 List of appendices

Appendix 1 – Patient Experience and Feedback Recovery and Improvement Plan, December 2022
Appendix 2 - Patient Experience & Feedback Quarterly Report (Q3)

Report Contact

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Patient Experience and Feedback

Recovery and Improvement Plan

December 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	PET 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	PET 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	PET Lead	31/03/22	PROs prioritised drafting backlog of responses	complete
1.5	Highlight 'ready to draft' responses: number, complexity	PET 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	PET 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	PET Lead / SPOC	31/03/23	Challenges remain with receiving statements within timescales. Long term sickness absence remains within PRD officer's workforce, however only as of 19/12/22 on d (3%) of complaints are with the PRD team in the drafting process As of 19/12/22, 72 (49%) stage 2 complaints are outstanding awaiting statement returns.	In progress

				New statement memo with aim to reduce duplication, streamlining processes and improving quality, awaiting testing Requested digital support to explore options for a shared document platform to support statement and final response processes. To implement a standard operating procedure to escalate delays in the process To process map delays within complaint handling process To review 20 final responses and discuss with services	
1.8	Analyse data from process mapping exercises and agree improvement trajectory with services	PET Lead / HoPE	31/12/22	Additional fields have been added to Datix to support data collection. This has allowed more meaningful data to be entered and exported direct to excel for interpretation. Weekly reports continue to be sent to the services generated from Datix. Weekly meetings with services reinstated to review current complaints and delays.	Complete
1.9	Establish focus groups to discuss complaints management with services	PET Lead / HoPE	31/03/23	Initial induction meetings have taken place with HoPE and several HoN and ADoN's. Questionnaires regarding the complaint handling processes, documentation and systems will be sent to the services prior to meeting.	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	31/12/22	Additional data fields have been added to Datix as a solution for extracting more detailed data. Ongoing national work regarding coding and categorization of complaints.	Complete
2.2	Data collection and analysis systems to be developed to facilitate 'live' status of complaints, avoid duplication, and enable bottlenecks to be identified	ADoN / HoPE	31/12/22	SharePoint not a viable solution for data collection and analysis system.	Complete

				Additional data fields have been added to Datix and data extracted to excel. This negates the need to manually update data onto an excel spreadsheet. Additional fields are being added to Datix for multi-directorate complaints and this will allow us to identify more easily services involved and track the progression of the whole complaint.	
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	PET Lead	31/03/23	Data systems are currently in place to gather this data. Further work is to be done to enhance the quality of the data. Complaints handling feedback Questionnaire has been designed to in relation to KPI-2 “Complaint Process Experience”. A new feedback questionnaire has been design using MS Forms and is due to be tested on 04/01/2022. A new feedback field has been added to Datix to capture patients that have consented to provide feedback. Initially this will be a test of change for Stage 2 complaints only and will then be spread out to cover all complaints and concerns. MS Forms will also capture live response rates and data that can be used for future learning and quality improvement.	In progress
2.5	Develop criteria against which quality of statements are assessed	PET Lead	31/03/23	Criteria has been developed against which quality of statements are assessed. This still needs to be tested and implemented	In progress
2.6	Develop criteria against which quality of draft responses are assessed	PET Lead	31/03/23	Criteria has been developed against which quality of draft response are assessed. This still needs to be tested and implemented	In progress
2.7	Develop criteria against which complaints are assessed as being upheld, not upheld or partially upheld	PET Lead	31/12/22	New complaint statement requests whether each complaint point is upheld or not upheld.	Complete

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
2.11	Complaint's dashboard	HoPE	31/03/23	Requested digital support to explore the extraction of data from Datix to produce a live Patient Experience Dashboard. Initial meeting to discuss is in January 2023.	In progress

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	PET Lead	31/12/22	Process mapping undertaken	Complete
3.2	Carry out detailed process map of PR administrators' work	PET Lead	22/4/22	Process mapping undertaken	Complete
3.3	Review outcomes and implement recommendations from process mapping sessions	HoPE	31/12/22	Outcomes reviewed and recommendations made	Complete
3.4	Benchmark complaints management teams / processes across other Boards and public sector agencies	PET Lead	31/12/22	Contact to be made with all Boards to review establishments, documentation, and processes	Complete
3.5	Process mapping analysis to elicit gaps, duplication, more efficient way of working	PET Lead	31/12/22	Process mapping completed with Quality Improvement project manager	Complete
3.6	Proactively seek feedback from complainants re the complaints handling process (as per KPI) (will also support QI)	PET Lead	31/12/22	Collating all forms of feedback from complainants and reviewing for learning opportunities	Complete
3.7	Poor uptake with feedback from complaints re the complaints handling process (as per KPI)	HoPE	31/03/23	A new feedback questionnaire has been design using MS Forms and is due to be tested on 04/01/2022. A new feedback field has been added to Datix to capture patients that have consented to provide feedback. Initially this will be a test of change for Stage 2 complaints only and will then be spread out to cover all complaints and concerns.	In progress

				MS Forms will also capture live response rates and data that can be used for future learning and quality improvement. This is being done as a Quality Improvement Project	
3.8	Sending email via Datix System	HoPE / PET Lead	30/09/22	Datix systems has been changed to allow the ability to send emails to recipients with NHS straight from the complaint file. This was not activated previously within the Complaints module. This allows direct emails from Datix rather than having to exit Datix, send from MS Mail, copy sent email and paste within the progress note in Datix complaint file. The ability to send emails from Datix has streamlined the process and is a more efficient way of working.	Completed

ISSUE: 4	'IMPROVING THE EXPERIENCE': QUALITY IMPROVEMENT				
OBJECTIVE	Ensure that lessons learned from all forms of patient feedback are used to inform quality improvement and promote patient safety				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
4.1	Link with Organisational Learning Group	ADoN / HoPE	06/10/22	OLG in early stages of development. ADoN co-Chair. Systems and processes being worked through	Completed
4.2	Identify small Tests of Change in department	ADoN	1/4/22	Blended approach to office working has been established, minimum 50% office-based	Complete
4.3	Identify small Tests of Change in Complaints Handling	PET Lead	31/12/22	Identify ToCs following review of outcomes and recommendations from process mapping	Complete
4.4	Review recorded answer phone message	HoPE / PET Lead		Review answer phone message – length, details Ensure information provide in answer phone message is accurate and update Consider allocated telephone extension for internal queries for NHS staff	Complete
4.5	Review complaint "Holding" Letter process	HoPE / PET Lead	30/09/22	Holding letters are issued every 20 days to complainants advising of delays in providing response letters. This has been changed to an email (where possible) which is a quicker process and releases time. The "Holding" letter/email has	Complete

				also been changed to reflect the feedback from patients who were unhappy with the content.	
4.6	Review of the Complaints “Acknowledgement” process	HoPE / PET Lead	31/12/22	Current review of the delays with complainants receiving “Acknowledgement” letters within 3 working days. The current way the data is extracted from Datix is not always accurate and false breaches are occurring. This continues to be reviewed monthly and true breaches looked at for learning opportunities. The report does not capture the data based on monthly performance. The data is pulled from the complaints closed date, therefore the breaches may be anything from 3 to 12 months old. New system in place to review complaints acknowledgement letters daily to help improve this target	Complete

ISSUE: 5	WORKFORCE				
OBJECTIVE	Ensure that PRT is supported and developed. Ensure that workload and workforce planning is considered in design of team				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
5.1	Support staff well-being	ADoN / HoPE	30/09/22	First ‘Spaces for listening’ session took place with Chaplain Service in July. Enquire about additional ‘Spaces for listening’ sessions. It is planned that these sessions will be provided every 3 months and staff are keen to continue with this. The second session took place 29/09/22.	Completed
5.2	Appoint additional PR officer via bank contract to focus on expediting draft responses	ADoN	1/5/22	Commences in post 31/5/22.	Complete
5.3	Leadership: recruit Head of Patient Experience (HoPE)	ADoN	7/4/22	Post appointed to	Complete
5.4	Ensure PDPs undertaken to support staff development	PET Lead	31/12/22	PDP’s have commenced	Complete

5.5	Source training opportunities for PRT	PET Lead	31/12/22	Ongoing training being sourced Good conversations training commenced SPSO training to commence in new year PDP's will highlight further training requirements	Complete
5.6	Develop system to categorise complaints from 'simple' to 'complex' to provide approximate time to draft response	HoPE / PET Lead	31/03/23	Complexity scoring system has been developed (similar to OPEL) and awaiting testing. New field added to Datix to capture data. Testing will begin January 2023 to ensure parameters are correct	In progress
5.7	Measure workload to support workforce planning	PET Lead	31/12/22	HoPE to confirm progress with PR Lead Twice weekly review of caseloads and ongoing review of roles and responsibilities as new systems, processes and roles develop	Complete
5.8	Review of PR team roles and responsibilities	HoPE / PET Lead	30/11/22	Review of systems and process along with tasks, roles and responsibilities continues to develop. Successful test of change with PR Support Officer reviewing incoming mail to PR department, releasing PR officers to draft complex complaints, this works well and will continue	Complete
5.9	Establishment and budget	HoPE / PET Lead	31/03/23	Benchmarking and reviewing current budget, establishment, banding and roles within PR department has taken place Review of current vacancies within establishment 9-month fixed term 0.69 WTE Band 4 PR Support Officers post has been appointed to and currently in post Administrator 1.0 WTE Band 4 post has been advertised and shortlisted, interviews January 2023 Continue to cover long term 0.8WTE Patient Experience Officer with Band 6 Bank 1.0 WTE (within establishment budget) 2 x 6-month fixed term Band 6 1.0WTE Patient Experience Officer post (Recruited to 1 post due to commence January 2023 and further interview to take place early January 2023 (both posts funded from underspend) Will test a new post in January 2023 approximately 10hrs per week to collect Patient Experience feedback	In progress

5.10	Rebranding of Team	HoPE / PET Lead	31/12/22	Rebranded Patient Relations Team to Patient Experience Team	Complete

Patient Experience and Feedback

PEaF Quarterly Report (Q3) for Clinical Governance Committee

October - December 2022

CONTENTS

Introduction

Person-centred Care

Person-centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How Do We Know We Are Getting It Right?

Defining the patient experience

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system. We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes and the environment.

Measuring the experience

'Patient experience and feedback' is captured by a number of different methods, including:

- Care Opinion
- Compliments and comments
- Complaints
- Care Assurance processes, for example: Shadowing / observation; Walkarounds; 15 step Challenge
- *Surveys (2022/23)*
- *Post discharge phone calls (2022/23)*

Improving the experience

It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Lessons learned, improvement actions developed, successes celebrated
- Create an enabling infrastructure: Framework; Leadership; Education and training
- Engage staff, patients, families and carers in improvement work
- *'Warm welcome / fond farewell' (2022/23)*
- 'You said… We did'
- *Focus groups (2022/23)*
- Initiatives, such as the Care Experience Improvement Model

Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning and making changes. NHS Fife is the top performing NHS Scotland Board.

NHS Fife's **Care Opinion** highlights for Q3 include:

- **223** stories, viewed **18,664** times in all:
  - October 80 stories
  - November 84 stories
  - December 69 stories

In Q3, Care Opinion moderators rated the stories as:

- Not critical 83% (194)
- Minimally critical 3% (6)
- Mildly Critical 9% (20)
- Moderately critical 5% (11)
- Strongly critical 1% (2)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made.

Compliments:
'Compliments', another vital component of patient feedback, is not routinely reported on. There is a 'compliments' section in the Datix Complaints module which is not widely used, and the following table only provides a small glimpse of positive patient feedback.

It is hoped that the 'compliments' module will become more widely used as staff are encouraged to record compliments, celebrating and learning from success. Compliments have increased by 94% from 182 in Q 4 (22/23) to 353 in Q3 (22/23).

Compliments	21/22 Q4	21/22 Q1	22/23 Q2	22/23 Q3	Total
Compliment	182	287	266	353	1088
Learning from Excellence	21	22	4	0	47
Comments and Feedback	6	10	4	8	28
Total	209	319	274	361	1163

Compliments	21/22 Q4	21/22 Q1	22/23 Q2	22/23 Q3	Total
Acute Services Division - Planned Care & Surgery	95	177	134	209	615
Community Care Services	51	50	57	65	223
No value	10	32	28	23	93
Primary and Preventative Care Services	14	19	14	25	72
Acute Services Division - Women, Children and Clinical Services	1	32	29	6	68
Complex and Critical Care Services	7	25	16	15	63
Community Services (Fife-Wide)	0	N/A	N/A	N/A	0
Community Services (West)	0	N/A	N/A	N/A	0
Acute Services Division - Emergency Care & Medicine	3	3	1	9	16
Community Services (East)	0	N/A	N/A	N/A	0
Corporate Directorates	1	0	0	1	2
Total	182	338	279	353	1152

Comments:

PALLIATIVE CARE – Patient was known for many years to the psychiatric services, was briefly a patient with your team last week, immediately prior to her death on Thursday. I have been asked by her brother to convey to you the heartfelt thanks of his family for the compassionate care they received from hospice staff and am very happy to do so.

PLANNED CARE – ADMISSION UNIT 2 - I could not have asked for better care since being admitted to AU2. All staff were polite, helpful, and comforting. I would like to mention Andrew. He has a lovely manner about him – his care is second to none. He makes you feel at ease, and his knowledge and approach outstanding. He is a credit to the NHS and is in the right role. I would also like to mention Fiona and Sarah who were also excellent during my time here. Thank you

WOMAN AND CHILDREN'S – I would like to say a massive thank you to all the midwives and doctors that dealt with me during my time in the Victoria Hospital. I went in on Tuesday 18th October and was out on Thursday 20th October. Every single member of staff that my partner and I dealt with were brilliant. They went above and beyond throughout our whole experience in the hospital.

Complaints:

Trends

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution

The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.

Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation

Complaints might be handled at stage 2 because:

- They are complex, serious or high-risk issues and are not suitable for early resolution
- early resolution has failed
- the complainant was unhappy with the outcome of stage 1 and asked for an investigation.

The complainant should receive a written response within 20 working days.

This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

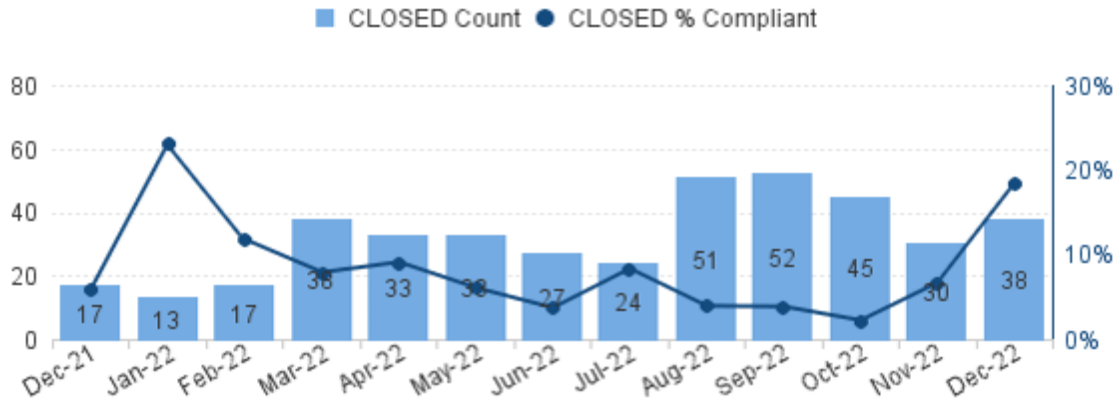
Records logged in Datix Complaints module – 01/10/2022-31/12/2022	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	Total
Stage 1 Complaint	113	109	151	122	495
Stage 2 Complaint	122	108	102	85	417
Concern	126	176	150	139	591
Enquiry	104	63	120	143	430
Total	465	456	523	489	1933

The pressures encountered in services because of the pandemic have led to difficulties in achieving the Model Complaints Handling Procedure timescales. Communication with complainants has been maintained by the Patient Experience Team over this difficult period. A Recovery and Improvement Plan has been developed to improve performance. The Model Complaints Handling Key Performance Indicators are appended to this report.

Stage 2 complaints have fallen for the 4th quarter in a row from 122 in Q4 (21/22) to 85 in Q3 (22/23) which is a 30% reduction in complaints.

Stage 2 closed complaints and % closed within timescale

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Closed Complaints	17	13	17	38	33	33	27	24	51	52	45	30	37
% closed within timescales	**5.9**	**23.1**	**11.8**	**7.9**	**9.1**	**6.1**	**3.7**	**8.3**	**3.9**	**3.8**	**2.2**	**6.7**	**18.4**



The above data metric is based on the closure date of the complaint and compliance with the 20-day completion target. We are reviewing a new metric which will be based on Stage 2 complaints that are open in the month and achieve the 20-day completion target. This will provide up to date monthly performance data.

Themes

The quarterly ranking of each theme is highlighted in brackets.

	Issue noted in Complaint	21/22 Q4	21/22 Q1	22/23 Q2	22/23 Q3
1	Disagreement with treatment / care plan	64 (1)	50 (2)	11 (1)	32 (1)
2	Co-ordination of clinical treatment	62 (2)	54 (1)	8 (2)	7 (4)
3	Staff attitude	46 (3)	32 (3)	5 (3)	13 (2)
4	Unacceptable time to wait for the appointment / admission	41 (4)	24 (4)	2 (7)	2 (10)
5	Lack of support	26 (5)	22 (5)	1 (9)	4 (7)
6	Telephone	24 (6)	0	3 (6)	4 (6)
7	Poor nursing care	18 (7)	16 (8)	5 (4)	5 (5)
8	Face to face	15 (8)	27 (7)	4 (5)	11 (3)
9	Lack of a clear explanation	15 (9)	22 (6)	2 (8)	1 (19)
10	Insensitive to patient needs			1 (10)	1 (15)
11	Patient has been sent no communication			1 (11)	1 (16)

The top 4 themes each quarter are:

- Disagreement with treatment / care plan
- Coordination of clinical treatment
- Staff attitude
- Unacceptable time to wait for the appointment / admission

These issues have been addressed at an individual level, but organisational learning must take place to improve practice and to improve the patient experience. The establishment of the Organisational Learning Group will support this endeavour.

Positive and Negative Themes

Positive themes (Care Opinion) Q3	Negative Themes (Care Opinion) Q3	Negative Themes (Complaints) Q3
Staff	Communication	Disagreement with treatment / care plan
Professional	Follow Up	Co-ordination of clinical treatment
Friendly	Care	Staff attitude
Nurses	Delays	Unacceptable time to wait for the appointment / admission
Communication	Waiting Time	Face to face
Care	Waiting Time	Lack of support
Caring	Cancellations	Poor nursing care

What was good?

What could be improved?

Locations receiving most complaints:

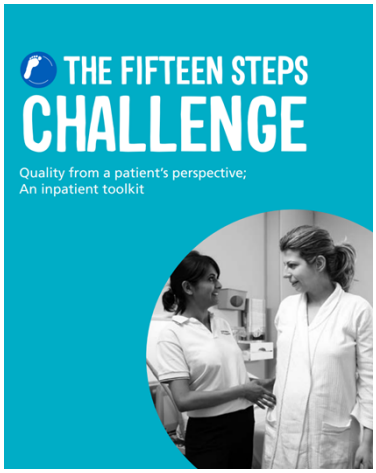
1. Emergency Department *(care and treatment; communication; staff attitude; delays)*
2. Mental Health (*treatment plan disagreement; communication; staff attitude)*
3. Medicine of the Elderly *(care and treatment; staff attitude; delay in discharge)*

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

Each quarter, this section will include feedback from patient / family surveys, complainant survey, patient and staff focus groups, and care assurance processes, including leadership walkrounds; 15 steps challenge; shadowing / observation; 'warm welcome / fond farewell' initiative; care experience improvement model.

Again, the impact of the pandemic has delayed the structured introduction of these processes although they have been happening on an ad hoc basis.



"The 15 Steps Challenge" is a suite of toolkits that explore different healthcare settings through the eyes of patients and relatives. With an easy-to-use methodology and alignment to NHS strategic drivers, these resources support staff to listen to patients and carers and understand the improvements that we can make. The toolkits help to explore patient experience and are a way of involving patients, carers and families in quality assurance processes.

The 15 steps challenge has been utilised in Glenrothes Hospital but, as we strive to improve patient experience, we will ask patients and their relatives to undertake the challenge.

The Model Complaints Handling procedure, KPI 2, relates to the Complaint Process Experience. Several methods to obtain feedback have been tested, but the results have been poor. Our feedback forms were sent out with the final response letter and often only returned when the complainant was dissatisfied with the complaint outcome, so we ceased to use these. These have been re-introduced, and again feedback has been poor.

A new Patient Experience Feedback questionnaire has been developed on Microsoft Forms to capture the experience of the person making the complaint in relation to the complaints handling process provided. Complainants will 'opt in' to provide feedback, this will be recorded on Datix, and the questionnaire will be sent out 2 -3 weeks after the complaint response letter. This will allow us to obtain feedback each month by contacting complainants who have opted in. Testing of this new process will commence in January 2023.

'Warm Welcome… Fond Farewell' is an initiative to standardise admission information and ensure consistent discharge planning. It will help address some of the themes identified in complaints around communication, lack of clear explanation.

The Head of Patient Experience will take forward these examples of patient experience improvement and will report on them in future reports.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2021	Jul to Sep 2021	Oct to Dec 2021	Jan to Mar 2022	2021 / 2022	Apr to Jun 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023
New SPSO cases	6	3	2	5	16	3	13	4		19
SPSO decisions	4	3	4	3	14	6	4	1		11
SPSO cases fully upheld	1	0	2	1	4	1	1	0		2
SPSO cases partly upheld	0	0	0	1	1	3	2	0		5
SPSO cases not upheld	2	3	2	1	8	2	1	1		4
Cases not taken forward	1	1	0	2	4	6	1	1		8

New SPSO cases this quarter	New SPSO decisions this quarter
This quarter, 3 new information requests have been received. These relate to the following services: • Planned Care: 1 • Women & Children & Clinical Services: 1 • Community Services Palliative Care: 1 • Corporate Services: 1	There was 1 new decision received from the SPSO this quarter. • 1 Not upheld

NHS Scotland Model Complaints Handling Procedure

Introduction

Empowering people to be at the centre of their care and listening to them, their carers' and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- to take a consistently person-centred approach to complaints handling across NHS Scotland
- to implement a standard process
- to ensure that NHS staff and people using NHS services have confidence in complaints handling
- encourage NHS organisations to learn from complaints in order to continuously improve services.

Complaints Performance Indicators

The CHP introduced nine key performance indicators by which NHS Boards and their service providers should measure and report performance. These indicators, together with reports on actions taken to improve services as a result of feedback, comments and concerns will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

Quarterly Reports

In accordance with THE PATIENT RIGHTS (FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS (SCOTLAND) DIRECTIONS 2017 (the 2017 Directions) relevant NHS bodies have a responsibility to gather and review information from their own services and their service providers on a quarterly basis in relation to complaints. Service providers (Primary Care) also have a duty to supply this information to their relevant NHS body as soon as is reasonably practicable after the end of the three month period to which it relates.

This quarterly report represents NHS Fife's response to the 2017 Directions and will form part of the Feedback and Complaints Annual Report for the Scottish Government. This section of the report is structured around the nine Key Performance Indicators.

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

- *Discussions taking place on how we proceed with this and the best way to capture this data.*
- *The Patient Experience Team is working collaboratively with the Organisation Learning Group and Clinical Governance to align learning from complaints and adverse events. This will ensure learning is shared and implemented across the wider organisation, to improve the quality of services that enhance the safety of the care system for everyone.*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided. NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *Complaints handling feedback forms were re-introduced in the first quarter with a poor response rate. The PDF form was changed to Microsoft Word to make it more user friendly however response rates remained poor.*
- *A new Patient Experience Feedback Questionnaire was created on MS Form and the new process will be tested in January 2023. The questionnaire will be sent to the complainant 2-3 weeks after the response letter and not with the response letter which was the previous process.*
- *An "opt in" option has been added to Datix which will be used to run a weekly report highlighting complainants that have given consent to participate in providing feedback.*

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q1	12	6	4	Figures provided for NHS, Social work / Fife Council, Voluntary Sector
	Q2	7	6	2	
	Q3	12	6	3	
	Q4				
Gc half- day intro course	Q1	0	0	0	
	Q2	3	7	2	
	Q3	8	7	5	
	Q4				
Gc Foundation Management		13			Good Conversations training is also provided as a half-da session on the 5 day Foundation Management programı
Human Factors		-			NES offer a range of training and information resources this topic – Learning page sites, presentations, Guidance webinars and posters. We are unable to report on engagement in these resources.
Duty of Candour Training	Q1	222			
	Q2	170			
	Q3	166			
	Q4				

Indicator Four: The total number of complaints received

****Please note** – we are unable to provide the data for Primary Care Services for Q3 (October to September 2022) for Indicators 4b and 4h-4k as the Primary Care Services request this information at the end of the quarter (beginning January 2023). As it takes a while to collate this information the data for Q3 will not be available until nearer the time of the next quarter. As such, we cannot complete the total figures for these services for Q4.

	Q4	Q1	Q2	Q3	Total
4a. Number of complaints received by the NHS Fife Board	155	217	253	235	860
4b. Number of complaints received by NHS Primary Care Service Contractors	114	211	198		523
4c. Total number of complaints received in the NHS Board area	**269**	**428**	**451**	**235**	**1383**

NHS Fife Board - sub-groups of complaints received

	Q4	Q1	Q2	Q3	Total
4d. General Practitioner	125	81	11	11	228
4e. Dental	1	1	3	1	6
4f. Ophthalmic	0	0	0	0	0
4g. Pharmacy	52	27	0	0	79
Total - Board managed Primary Care services	**178**	**109**	**14**	**12**	**313**
	Q4	**Q1**	**Q2**	**Q3**	**Total**

4h. General Practitioner	81	128	77		
4i. Dental	1	3	3		
4j. Ophthalmic	0	0	2		
4k. Pharmacy	27	80	121		
Total – Independent Contractors	**109**	**211**	**198**		
4l. Combined total of Primary Care Service complaints	**287**	**320**	**212**		

Indicator Five: Complaints closed at each stage

	Number				**As a % of all NHS Fife complaints closed (not contractors)**			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Number of complaints closed by the NHS Board *(do not include contractor data, withdrawn cases or cases where consent not received).*	**155**	**132**	**264**	**235**				
5a. Stage One	87	107	136	123	56%	81%	51%	52%
5b. Stage two – non escalated	59	24	110	95	38%	18%	42%	41%
5c. Stage two - escalated	9	1	18	17	6%	1%	7%	7%
5d. Total complaints closed by NHS Board	**155**	**132**	**264**	**235**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld and not upheld

Stage one complaints	**Number**				**As a % of all complaints closed by NHS Fife at stage one**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
6a. Number of complaints upheld at stage one	16	24	35	36	19%	25%	29%	35%
6b. Number of complaints not upheld at stage one	53	51	63	42	63%	52%	52%	41%
6c. Number of complaints partially upheld at stage one	15	23	23	24	18%	23%	19%	24%
6d. Total stage one complaints outcomes	**84**	**98**	**121**	**102**	**100%**	**100%**	**100%**	**100%**

Stage two complaints Non-escalated complaints	Number				As a % of all non-escalated complaints closed by NHS Fife at stage two			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
6e. Number of non-escalated complaints **upheld** at stage two	1	8	13	18	6%	42%	25.5%	30%
6f. Number of non-escalated complaints **not upheld** at stage two	9	9	25	23	53%	47%	49%	38%
6g. Number of non-escalated complaints **partially upheld** at stage two	7	2	13	19	41%	11%	25.5%	32%
6h. Total stage two, non-escalated complaints outcomes	**17**	**19**	**51**	**60**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints Escalated complaints	Number				As a % of all escalated complaints closed by NHS Fife at stage two			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
6i. Number of escalated complaints **upheld** at stage two	1	0	2	1	14%	0%	14%	7%
6j. Number of escalated complaints **not upheld** at stage two	3	1	9	10	43%	100%	65%	67%
6k. Number of escalated complaints **partially upheld** at stage two	3	0	3	4	43%	0%	21%	26%
6l. Total stage two escalated complaints outcomes	**7**	**1**	**14**	**15**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times

	Q4	Q1	Q2	Q3
7a. the average time in working days to respond to complaints at stage one	7.2	5.9	14.2	14.1
7b. the average time in working days to respond to complaints at stage two	69.4	44.0	93.8	98.7
7c. the average time in working days to respond to complaints after escalation	84.1	33.0	102.4	66.4

Indicator Eight: Complaints closed in full within the timescales

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
8a. Number of complaints closed at stage one within 5 working days.	52	75	83	60	87%	94%	93%	87%
8b. Number of non-escalated complaints closed at stage two within 20 working days	8	5	5	5	13%	6%	6%	7%
8c. Number of escalated complaints closed at stage two within 20 working days	0	0	1	4	0%	0%	1%	6%
8d. Total number of complaints closed within timescales	**60**	**80**	**89**	**69**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorized

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
9a. Number of complaints closed at stage one where extension was authorised	10	12	19	16	27%	38%	35%	27%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	27	20	36	44	73%	62%	65%	73%
9c. Total number of extensions authorised	**37**	**32**	**55**	**60**	**100%**	**100%**	**100%**	**100%**

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

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

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

NHS Fife

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NHS Fife

Meeting:	**Clinical Governance Group**
Meeting date:	**3 March 2023**
Title:	**Annual Duty of Candour Report 2021/2022**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Shirley-Anne Savage, Associate Director for Quality and Clinical Governance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance
- Decision
- Discussion

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Annually there is a requirement for Health Boards to publish an Annual Duty of Candour (DoC) Report. Incidents which trigger DoC are typically identified through the adverse event review process.

2.2 Background

As of 1 April 2018, all health and social care services in Scotland have an organisational Dutyof Candour (DoC). The purpose of organisational DoC is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness

or underlying condition. This is a legal requirement which meansthat when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to befollowed is set out in the Duty of Candour (Scotland) Regulations 2018.

NHS Fife monitor compliance with the Regulations across the following domains:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Review of reports for 2018/2019, 2019/2020 and 2020/2021 indicated the there is still a requirement for each report to include a look back at previous years to ensure completeness. In previous years DoC applied to cases which concluded review after the submission of respective annual submissions and as such these were not represented in the annual report.

2.3 Assessment

There were 36 adverse events requiring DoC with the most common outcome, for 20 patients, being an increase in a person's treatment.

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified including notifying the person and providing details of the incident, provision of an apology, reviewing all cases and offering support and assistance. There was Improvement since last year on providing the patient with a written apology. There was one area identified for improvement and that was arranging a meeting following an offer to meet.

The pandemic and the proceeding years have resulted in delays in the completion of adverse event reviews. In view of the delays in completing adverse event reviews and the commitment to providing a comprehensive annual report it was agreed that the reports should be presented in January each year proceeding the end of the reporting period.

The Adverse Events Team are working with services to support completion of the outstanding compliance feedback and to conclude adverse event reviews.

In order to conclude the 2021/2022 annual report the following remain outstanding:

Compliance

- Completion of 6 audit forms to assess compliance with DoC Regulations
- Confirmation of the primary outcome for 1 incident

Adverse Events

- 11 Significant Adverse Event Reviews awaiting submission of final report
- 32 Local Adverse Event Reviews pending

Currently for 2022/23 we have 8 confirmed DoC (including 4 tissue viability and 3 falls) with 9 outcomes recorded (7 being an increase in treatment). It has again been agreed that the full report should be presented January 2024.

2.3.1 Quality/ Patient Care

The learning from adverse event and DoC incidents continues to be a priority. Development of this will be supported through the Clinical Governance Framework.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

As above, support is in place from the Adverse Events Team to conclude outstanding compliance feedback and adverse event reviews.

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 report has been discussed with Dr Chris McKenna, Medical Director.

2.3.8 Route to the Meeting

14th February 2023: Clinical Governance Oversight Group
16th February 2023: Executive Directors' Group

2.4 Recommendation

- **Assurance**
- **Discuss** and **review** the substance and content of the report with a view to the final report being presented in May 2023.

Any incidents that conclude after submission of the 2021/2022 report will then be included in the 2022/2023 report.

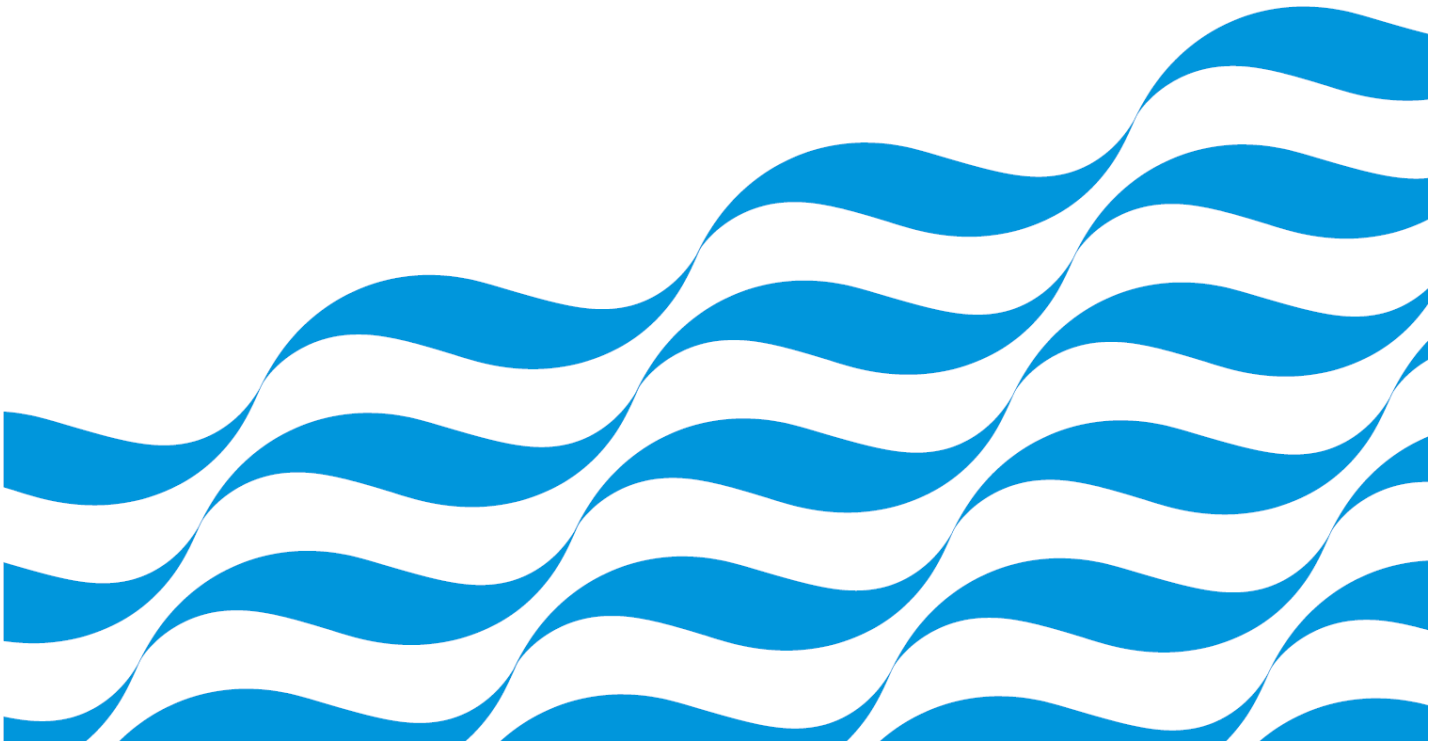
3 List of appendices

The following appendices are included with this report:

- Appendix 1: Annual Duty of Candour Report, 2021/2022

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

Annual Organisational Duty of Candour Report 2021-2022



Contents

1. Introduction and background

NHS Fife

NHS Fife serves a population of approximately 368,000 people. Our vision is to enable the people of Fife to live long and healthy lives. We strive to achieve this by transforming health and care in Fife to be the best.[1]

Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations during the period 1 April 2021 to 31 March 2022 (2021/2022). NHS Fife identified these events mostly through its adverse event management processes. The organisation adopts a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and which is aligned with a national framework[2].

The Covid-19 pandemic and the system pressures in proceeding years has resulted in a delay to the completion of adverse event reviews. This is reviewed regularly with processes in place to ensure reviews are progressed and completed. Consequently there are a number of events reported during this period which are currently under review and which may be reported as activating organisational DoC. It is therefore possible that the number of reported DoC events may be higher than stated in this report. Only those events with a confirmed decision have been included in this report.

A look back at years 1 (2018/2019), 2 (2019/2020) and 3 (2020/2021) is also included in this report. Previous years are included for completeness as DoC applied to cases which concluded review after the submission of respective annual reports. Also contained in appendix 1-4 are organisational DoC reports from the four health board managed general practices in NHS Fife.

Organisational Duty of Candour

As of 1 April 2018, all health and social care services in Scotland have an organisational Duty of Candour. The purpose of the duty of candour is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition. This is a legal requirement which means that when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to be followed is set out in the Duty of Candour (Scotland) Regulations 2018.

The Organisational Duty of Candour guidance[3] outlines the procedure which must be a followed as soon as reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:

  (a) the incident appears to have resulted in or could result in any of the outcomes below (see Table 1).

  (b) the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

This means if a patient suffers from an unintended or unexpected harm as a result of an adverse event then the following should happen:

- The patient or relative is notified and an apology is offered;
- An investigation is undertaken; and
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation

NHS Fife has an embedded process for the decision making for activating organisational DoC and ensuring all necessary actions are undertaken in accordance with national guidance. On review, any event which is considered to activate duty of candour is escalated to the Board Medical Director for ratification and confirmation of decision. This process is summarised in the following:

- On completion of the investigation the findings and report are offered to be shared with the patient or relative;
- A meeting is offered; and
- Throughout the review and investigation support is to be offered to the people affected which may include staff members involved.

The outcome for organisations is to learn from the investigation and make changes identified as part of the review.

[1] NHS Fife Strategic Framework. 2015.

[2] Learning from adverse events through reporting and review: A national framework for Scotland, revised July2018, NHS Fife review all adverse events.

[3] Organisational Duty of Candour guidance. The Scottish Government. March 2018

2. How many adverse events happened to which the duty of candour applies?

Between 1 April 2021 and 31 March 2022, there were 36 adverse events reported where DoC applied. The main categories of event which activated DoC during this period were:

- Tissue Viability
- Theatre / Surgery Incidents
- Other clinical events

Table 1 details the outcomes which were reported across NHS Fife after 1 April 2021 to 31 March 2022.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred 2021/2022
The death of the person	6
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5
An increase in the person's treatment	20
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	<5
The person requiring treatment by a registered health professional in order to prevent: the death of the person, or any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5

The most common outcome which these events have resulted in is an increase in the person's treatment. This can range from additional antibiotics required to additional night's stay in hospital.

Summary of Years 1-4

Table 2 sets out the events where DoC applied in 2018/2019, 2019/2020, 2020/2021 and 2021/2022. This additional information is being included for completeness as DoC was applicable to events which concluded review after respective annual reports were submitted.

The number of events where DoC applied in year 1 is higher than the subsequent years. This can be attributed to the development of learning and understanding of the application of DoC Regulations.

Table 2

Number of Duty of Candour events in each report year	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22
Number of events where DoC applied and where included in respective annual report	46	28	27	36*
Number of events where DoC applied and where not included in annual report	10	10	<5	TBD **
Total number of events where DoC applied	56	38	31	TBD **

*1 event for 3 patients / *To Be Determined (TBD) - Will be included in 22/23 annual report

Table 3 sets out the DoC outcomes for the three year period. Across this period the most common outcome is an increase in the person's treatment.

Table 3

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred			
	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22
The death of the person	<5	<5	<5	6
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5	<5	<5	<5
An increase in the person's treatment	34	21	13	20
Changes to the structure of the person's body	<5	<5	<5	0
The shortening of the life expectancy of the person	<5	<5	<5	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	<5	0	0	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	8	<5	<5	<5
The person requiring treatment by a registered health professional in order to prevent the death of the person, or any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5	7	<5	<5

3. To what extent did NHS Fife follow the duty of candour procedure?

Of the 36 identified cases, each one was reviewed to assess for compliance with the procedure for the following elements:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified. These are:

- Notifying the person and providing details of the incident
- Provision of an apology
- Reviewing all cases
- Offering support and assistance

Improvement since last year has been made in:

- Providing the patient with a written apology

Areas for improvement which are attributable to the pressures in the system include:

- Arranging the meeting following offer to meet

We know that witnessing or being involved in an adverse event can be distressing for staff as well as people who receive care. Support is available for all staff through our line management structures as well as through Staff Wellbeing and Safety.

4. Information about our policies and procedures

Every adverse event which occurs is reported through our local reporting system as set out in our Adverse Events policy and associated processes. Through these, we can identify events that activate the DoC procedure.

The policy contains a section on implementing the organisational DoC, and a detailed section about supporting staff and persons affected by the adverse events, with examples of the types of support available.

Each adverse event is reviewed to understand what happened and the actions we can take to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the review, and local management teams develop action plans to meet these recommendations.

Clinical teams make the recommendation that Duty of Candour is activated with the final decision made by the Medical Director.

To support implementation of DoC, staff are encouraged to complete the NHS Education Scotland on line learning module. This has been made available to staff through TURAS. In addition to the above policy to ensure our practice and services are safe, theorganisation has clinical policies and procedures. These are reviewed regularly to ensure they remain up to date and reflective of current practices. Training and education are madeavailable to all staff through mandatory programmes and developmental opportunities relating to specific areas of interest or area of work.

5. What has changed as a result?

Further to reviews of DoC events in 2021/2022 the following changes have been implemented:

- Tissue viability specialist nurses in partnership with the tissue viability link nurses identified pressure related ward level training and delivered the training to all ward staff. This included the accurate completion of wound care documentation and the importance of clear and accurate wound charts
- Review of the dietetic referral criteria for patients with pressure damage ensuring patients are referred
- Further supportive learning delivered to staff regarding correct identification/ grading of pressure ulcers
- Further education delivered on central venous catheter (CVC) care bundle
- Plaster cast referral form was reviewed to ensure patients who are high risk of pressure damage can be clearly identified
- Introduction of new monitoring chart for high dose insulin euglycaemic therapy
- Delivery of a further training session for stroke including review of four case studies
- The latent phase of labour guideline was reviewed to include bladder care and time frames for review to allow more flexibility to individual patient condition. The management of the latent phase of labour is now included in regular skill and drills in the Midwife-Led Unit
- In orthopaedic theatres when implants are being used the stop & check engagement between theatre staff is now carried out routinely before the list starts and at the various stages during the operation
- For complex patient transfers from critical care to ward level care Medical High Dependency Unit (MHDU) step down is now part of the consideration
- Post intravitreal injection therapy (IVT) patients who phone the Ophthalmology Dept with reported complications will now be seen in the Emergency Clinic for an urgent review
- An endometrial biopsy is now obtained in the post-menopausal bleeding clinic even when the scan suggests uterine polyp, with referral made to the hysteroscopy clinic to manage the polyp whilst awaiting the histology report.

Given the delays described in this report it is anticipated that more changes will be implemented following conclusion of events which are still under review. These will be captured in the 2022/2023 annual report.

If you would like more information about this report, please contact

Board Medical Director Office
NHS Fife
Hayfield House
Hayfield Road
Victoria Hospital
Kirkcaldy
KY2 5AH
Telephone: 01592 648077

Appendix 1: Linburn Road Health Centre

Linburn Road Health Centre
124 Nith Street
Dunfermline, KY11 4LT
Tel: 01383 733490
Fax: 01383 748758
Email: Fife.F20502LinburnRoad@nhs.scot

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

Duty of Candour Report

Report period: 1 April 2021 to 31 March 2022

Completed by: Sharon Duncan, Practice Manager (Job Share)

Linburn Road Health Centre provides Health Care to patients within the Dunfermline and Rosyth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2021 and 31 March 2022)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Linburn Road Health Centre follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Kinghorn Medical Practice

Kinghorn Medical Practice
Rossland Place
Kinghorn
Fife
KY3 9RT
Tel: 01592 890217

Duty of Candour Report

Report period: 1 October 2021 to 31 March 2022

Completed by: Fay Paterson, Practice Manager

Kinghorn Medical Practice provides general medical services to around 3360 registered patients residing within the practice boundary which encompasses Burntisland, Kinghorn and the bottom part of Kirkcaldy and some surrounding rural areas. Our mission is to provide a personal quality service making the best use of available resources.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 October 2021 and 31 March 2022)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Lochgelly Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 3: The Links Practice

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF

Tel: 01592 873321

Dr J Yule
M.B.,Ch.B.,D.C.H., M.R.C.G.P.

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

This short report describes how our care service has operated the duty of candour during the time between 1st April 2021 to 31st March 2022. We hope you find this report useful.

Our Practice serves a population of 1972 patients within the Burntisland, Kinghorn, Aberdour area.

How many Incidents happened to which the duty of Candour applies?

In the last year, there have been no incidents to which the duty of candour applied.

Information about our policies and procedures.

Where something has happened that triggers the duty of candour, our staff report this to the Practice Manager who has responsibility for ensuring that the Duty of candour procedure is followed. The Practice Manager records the incident and reports as necessary to the Health Board. When an incident has happened, the Manager and staff set up a learning review. This allows everyone involved to review what happened and identifies changes for the future.

If you would like more information about The Links Practice, please contact us using these details.

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife
KY3 9JD

Tel: 01592 873321
Email: Fife.F20184LinksPractice@nhs.scot

Appendix 4: Valleyfield Medical Practice

Valleyfield Medical Practice
Chapel Street, High Valleyfield
Fife, KY12 8SJ
Tel: 01383 880511
Email: Fife.F20729valleyfield@nhs.scot

Duty of Candour Report

Report period: 1 April 2021 to 31 March 2022

Completed by: Michelle Parker, Practice Manager

Valleyfield Medical Practice provides Health Care to patients within the High Valleyfield, Low Valleyfield, Culross, Torryburn, Newmills, Cairneyhill and Crossford. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2021 and 31 March 2022)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 5: Methilhaven Medical Practice

Methilhaven Medical Practice
Randolph Wemyss Hospital,
Wellesley Road
Buckhaven KY8 1HU
Tel: 01333 426913
Email: fife.f21505methilhaven@nhs.scot

Duty of Candour Report

Report period: 1 April 2021 to 31 March 2022

Completed by: Tracy Simpson, Acting Practice Manager

Methilhaven Surgery provides Health Care to patients within the Methil, Buckhaven, and Levenmouth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2021 and 31 March 2022)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

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.EqualityandHumanRights@nhs.scot or phone 01592 729130

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

www.nhsfife.org

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Annual Child Death Review Report 2022**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Claire Fulton, Lead for Adverse Events**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Person Centred
- Effective

2 Report summary

2.1 Situation

Annually there is a requirement for Health Boards to publish a Children and Young Person's Death Review Report.

2.2 Background

Scotland has a higher child mortality rate for the under 18s than any other Western European Country, with approximately 350 – 450 children and young people dying annually. It is estimated that a high proportion of these deaths could be prevented. This sobering data prompted the Scottish Government to request that a system be established for the reviewing and learning from the deaths of children and young people.

On 1st October 2021 a National system for the reviewing and learning from the deaths of children and young people was established. Healthcare Improvement Scotland (HIS) is responsible for overseeing death review activity through the National Hub. The National Hub will ensure that the death of every child and young person is

reviewed to a minimum standard; defined within the National core data set.

Within scope are all deaths of children and young people up to their 18th Birthday and also those up to their 26th Birthday if they continue to receive aftercare or continuing care at the time of their death.

The Fife Partnership Review of Children and Young People Deaths Commissioning Group was established in October 2021. The commissioning group's core membership is multi-disciplinary and multi-agency. This collaborative approach is central to achieving the requirements of the national guidance in delivering a high quality review which supports learning and improvement, both locally and nationally, from every child or young person's death in Scotland.

2.3 Assessment

On the completion of 2022 there were 19 deaths which met criteria for review. This suggests that the number of deaths reviewed in 2022 was lower than the anticipated 30 – 35 reviews per annum, calculated from the last 5 years average. All 19 deaths have been discussed at the monthly commissioning group.

2.3.1 Quality/ Patient Care

All the key requirements of the national guidelines are being achieved with the exception of

- Engaging families to the full capacity that is outlined within the National requirements.
- The submission of completed data sets to the National Hub. This is out with the partnerships control and a date is awaited from HIS

2.3.2 Workforce

The substantive staffing of the Child Death Review Team consists of dedicated Lead Paediatric Consultant, Band 7 Child Death Review Coordinator and Band 4 Administration support.

2.3.3 Financial

The costs associated with the workforce were met by NHS Fife.

2.3.4 Risk Assessment/Management

The child death review process is at the early stages of standardising the process for looked after children, suspected suicides and accidental deaths. While the process is scoped and embedded there is a risk of duplication of review. Work is underway with partnership colleagues to ensure that the process dovetails.

2.3.5 Equality and Diversity, including health inequalities

An Equality Impact Assessment (EQIA) stage 1 was completed for the child death review process and has been published on the NHS Fife website. Equality Impact Assessment (EQIA) | NHS Fife

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This report has been discussed and agreed with Mrs Janette Keenan, Director of Nursing.

2.3.8 Route to the Meeting

Executive Directors Group 16 February 2023

2.4 Recommendation

Clinical Governance Committee are asked to take **assurance** from the content of the report.

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Annual Fife Partnership Review of children and young people deaths 2022

Report Contact
Claire Fulton
Lead for Adverse Events
Claire.fulton@nhs.scot

Annual Report
Fife Partnership
Children and Young Person's Death Review
2022

Contents

1. Introduction and Background

In 2014 the Scottish Government published the findings of a report by the Scottish Government Child Death Review Working Group[1]. It detailed that Scotland has a higher mortality rate for the under 18s than any other Western European country, with between 350 and 450 children and young people dying every year. It is estimated that around a quarter of the deaths recorded could be prevented. The report also identified that there is considerable geographical variation across Scotland and multiple different mechanisms for informal and formal reviews of child deaths, with no national system to support quality reviews or share learning. The report concluded that every child death deserves a review. The overarching purpose of the review will be to ensure that information is collected and learning shared locally and nationally which may prevent future child deaths or contribute to child health and wellbeing.

The key recommendation of the working group was that a national system be established for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland, with an aim to co-ordinate all current review activity. To address this recommendation a National Hub was established, co-hosted by Healthcare Improvement Scotland and the Care Inspectorate. Following an initial scoping exercise the National Hub devised guidance which sets out the process NHS boards and local authorities should follow when responding to, and reviewing, the death of a child or young person.

The Fife Partnership serves a population of approximately 374,730 people with 102,541 being under the age of 25[2]. An average calculated from the 5 years prior to 2021 predicted that Fife would be required to undertake 30-35 child and young person's death reviews per annum.

This first annual report details how NHS Fife and Fife local authorities have responded to the national guidance, details progress made, the next key steps and provides an overview of the child deaths recorded and reviewed in Fife in 2022.

2. Progress

The Fife Children & Young People Deaths Review Partnership was set up in October 2021. There are 2 well established strands of the partnership which are detailed in section 2.2.

The collaborative approach between NHS Board and partner agencies has been successful in developing excellent working relationships. The partnership approach ensures, in line with the National Guidance, that there is no unnecessary duplication

in reviews and that information is collated and that learning is shared. Communication and interaction with other NHS Boards where joint board reviews are required, continues to strengthen while the process embeds across Scotland.

Substantive funding provided by NHS Fife seen the establishment of a dedicated Child Death Review Team, this has allowed facilitation of reviews of all board area child deaths in 2022 and identifying of mechanisms for family support following bereavement that extends to the inclusion of families in the review process.

An Equality Impact Assessment (EQIA) was carried out to ensure the Child Death Review (CDR) process met the obligations set out by the Equality Act 2010, the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and the Human Rights Act 1998. The EQIA is accessible on the NHS Fife Website.

An NHS Fife learning event led by the Child Death Review Lead has taken place providing the opportunity to raise awareness of the Child Death Review Team, their function, key goals and sharing of relevant early learning points.

2.1 Challenges

As the review process has been embedded it has been identified that we require a mechanism to streamline and translate the outcome of organisation and agency based review into usable data to fulfil the requirements of the National Hub data set. Examples of these reviews are significant adverse events review (SAER) commissioned and governed by NHS Fife, Learning Reviews commissioned by the Child or Adult Protection Committees and reports relating to the death of Looked After Children governed by the Care Inspectorate.

In addition to the well established review process, as above, consideration is required of the instatement of bespoke sessions to review child deaths that fall out with the current governance structures.

The opportunity for sharing learning nationally has been delayed. Fife completed child death reviews have not been uploaded to the online National Hub reporting portal. This has been delayed due to various reasons within the national hub and a definitive date is still awaited.

2.2 Process

Fife Children & Young People Deaths Review Partnership Commissioning Group is an operational level group meeting monthly. Core membership is multi-disciplinary and multi- agency, this collaborative approach is central to achieving the requirements of the national guidance.

The key purpose of this group is to ensure the death of every child *(all live born children up to the date of their 18th Birthday, or 26th Birthday for care leavers who are in receipt of aftercare or continuing care from Social Work Services at the time of their death)* who at time of death has a home address that is within Fife's geographical area, is subject to a quality review by

- Developing a methodology and documentation to ensure all deaths are reviewed through a high quality and consistent process
- Improving the quality and consistency of existing reviews
- Improving the experiences of families and carers, and
- Channelling learning from current processes to help reduce preventable deaths

Fife Children & Young People Deaths Review Partnership Governance Group, Chaired by the Child Heath Commissioner meets a minimum of 3 times per year. The group provides scrutiny of the work of the commissioning group to ensure fulfilment of national recommendations and provide assurance to NHS Fife Board and Children in Fife Partnership Group on the process, quality and learning from child and young person's deaths in Fife.

Table 1 details the status of the reviews at year end.

Table 1

Stage of Review	Total
Summary to Commissioning Group within 1 month of Notification of Death	19
Multi-agency reviews performed	12
Multi-agency reviews to be arranged	< 5
Awaiting completion of reports	8
Review completed. Data set and report to be finalised	< 5
Completed Reviews	< 5

3. Summary of cases

Over the 1 year period from January 1st 2022 – 31st December 2022 there have been 19 children and young people's deaths that lived in Fife reported and met criteria for review. Currently this number suggests the number of deaths requiring review this year was slightly lower than the anticipated 30-35 reviews per annum. All deaths have been subjected to a robust review, discussed at the monthly commissioning **group** and learning **shared** locally.

- **9** of the **19 deaths** were **expected** deaths, under the categories of prematurity of the newborn with associate complications and genetic or life limiting illness including teenage cancer.
- **10** of the **19 deaths** were **unexpected**.

Table 2 sets out the number of deaths per age category.

Table 3 sets out the place of death. The number of deaths occurring out with Fife in other NHS boards is due to children and young people with very serious conditions requiring transfer to specialist services in tertiary units. The Fife Partnership remains responsible for ensuring a robust review is carried out and that the dataset is completed and uploaded to the National Hub once this is up and running.

There have been no deaths reported in the over 18 age category that are in receipt of aftercare or continuing care.

Data is pooled into 3 age categories and 3 locations at time of death. Owing to the relatively small numbers, this approach is taken to ensure anonymity. A disadvantage to this is that subtle differences that may be important are disguised. Any calculations based on small numbers should be interpreted with caution and in conjunction with other relevant information. On collation of the National Report these nuances may be of more significance. The report excludes figures of registered deaths causes and outcomes due to the small number and to prevent accidental disclosure of a child or young person being identified.

Table 2

Age at time of death	Total
< 1 year old	7
1 – 10 years old	5
10 – 18 years old	7

Table 3

Location at time of death	Total
NHS Fife Hospital	< 5
Other NHS Board	8
Community based	9

4. Learning

The key learning highlighted in 2022 relates mostly to the complexities around the development of processes within a multi-disciplinary and multi-agency partnership. There has had a particular focus on streamlining existing review process that currently coincide into a single review process.

It has become clear that often different agency reviews need to run concurrently and brought together within the CDR process once all of the reviews have been finalised.

TEAMS have played an important role in being able to facilitate multi-disciplinary and multi-agency reviews.

Specific learning has been identified within individual services; due to identifiable factors this learning is not able to be included within this report.

5. Next steps

In spring 2023 the National Hub will launch an information leaflet on Child Death Review for families and carers. On publication, this will be adopted locally and utilised to support earlier engagement with families.

Following on from the success of the local event where learning was shared within NHS Fife, a mechanism requires to be developed that creates an opportunity to share learning more widely across all partnership and relevant agencies.

Work will continue in collaboration with the National Hub to submit data, contributing to opportunities for national learning.

6. References

1. Child Death Review Report: Scottish Government Child Death Review Working Group. Accessed from - (www.gov.scot)
2. National Records of Scotland Preserving the past, Recording the present, Informing the future. Accessed from - www.nrscotland.gov.uk

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**	✓			**Deferred to next mtg**
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Board Assurance Framework - Quality and Safety	**Medical Director / Director of Nursing**	✓	✓	✓	**Corporate Risks replaced this item**		
Board Assurance Framework - Strategic Planning	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓	✓	✓	**Corporate Risks replaced this item**		

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**	✓	✓	✓	**Corporate Risks replaced this item**		
Corporate Risks Aligned to CGC	**Medical Director/Director of Nursing**				✓	✓	**Covid-19 Pandemic**
Strategy / Planning							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Cancer Framework and Delivery Plan	**Medical Director**					✓	✓ **Added**
Clinical Governance Framework and Delivery Plan	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg**	**Deferred to Nov '22**		✓	✓	
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
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**				✓		
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 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**				✓ Annual Report		
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			Removed – no update
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**	✓ Q4 Report	✓ Q1 Report	✓	✓ Q2 Report	✓	✓ Q3 Report
Volunteering Report	**Director of Nursing**				✓ Annual Report		
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			Deferred to May '23	
Annual Resilience Report	**Medical Director**						Deferred to July '23
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Digital and Information Annual Report	**Associate Director of Digital & Information**					Deferred to next mtg	Deferred to next mtg

Annual Reports (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Director of Public Health Annual Report (also goes to PHWC)	**Director of Public Health**	**Deferred to next mtg (due to timings)**	✓				
NHS Fife Equality Outcomes Progress Report	**Director of Nursing**					✓ **2023 Report**	
Fife Child Protection Annual Report	**Director of Nursing**					✓ **Deferred to April 2023**	
Health & Safety Subcommittee Annual Report	**Director of Property & Asset Management**						**Deferred to next mtg**
IJB Quality & Communities Annual Report	**Medical Director**						**Deferred to next mtg**
Information Governance & Security Steering Group	**Associate Director of Digital & Information**						**Deferred to next mtg**
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**	✓			**Deferred to next mtg**
Organisational Duty of Candour Annual Report	**Medical Director**				**Deferred to March 2023**		✓
Participation & Engagement Report *(also goes to PHWC)*	**Director of Nursing**		**Presented in Jan '22**		✓ **Combined with Quality Framework Report**		
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	

Annual Reports (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
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**						✓
Quality Framework for Participation & Engagement Self-Evaluation	**Director of Nursing**			**Deferred to next mtg**	✓ **Combined with Participation & Engagement**		
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	✓ 07/09	✓ 16/11	**Removed – now reports into Clinical Governance Oversight Group**
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 **mtg cancelled**	✓ 11/10	✓ 13/12
Area Radiation Protection Committee	**Medical Director**	✓ 02/03					
Cancer Governance & Strategy Group	**Medical Director**	01/04 **mtg cancelled**		✓ 02/06		✓ 19/08 & 04/11	✓ 13/01
Clinical Governance Oversight Group	**Medical Director**	✓ 15/02	✓ 19/04	✓ 14/06	✓ 16/08	✓ 18/10	✓ 20/12
Digital & Information Board	**Medical Director**		✓ 19/04	✓ 28/07	✓ 18/10		✓ 24/01

Linked Committee Minutes (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Fife Drugs & Therapeutic Committee	**Medical Director**	✓ 09/02	✓ 27/04	✓ 22/06	✓ 24/08 & 12/10	✓ 07/12	✓ 08/02
Fife IJB Quality & Communities Committee	**Associate Medical Director**	✓ 04/03	✓ 20/04	✓ 05/07	✓ 09/09		✓ 08/11 & 18/01
Health & Safety Subcommittee	**Chair of Sub-Committee**	✓ 11/03		✓ 10/06	09/09 **mtg cancelled**		09/12 **mtg cancelled**
Infection Control Committee	**Director of Nursing**	✓ 02/02 06/04 **mtg cancelled**		✓ 08/06 & 03/08		✓ 05/10 & 07/12	
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		✓ 11/10	✓ 31/01
NHS Fife Medical Devices Group *(New group formed in June 2022)*	**Medical Director**				✓ 16/08	08/12 **mtg cancelled**	
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 31/03	✓ ~~24/05~~ 20/06		✓ 22/09	✓ 14/12	
Resilience Forum	**Director of Public Health**				✓ 25/08		✓ 01/12
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)**				

Ad Hoc Items (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
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**			✓			
Hospital Standardised Mortality Ratio (HSMR) Update Report	**Medical Director**				✓ **Matters arising item**		
Records Management National Registers of Scotland Keeper Report	**Associate Director of Digital & Information**					✓	
Strategic Planning & Resource Allocation 2023-24	**Director of Finance & Strategy**				✓		✓
Annual Delivery Plan & Winter Actions	**Associate Director of Planning & Performance**				✓		
Laboratory Information Management System Update	**Associate Director of Digital & Information**				✓		
Population Health & Wellbeing Strategy	**Director of Finance & Strategy**					✓	
NHS Fife Response to the Letter from Health Improvement Scotland	**Medical Director**					✓	
High Risk Pain Medicines Patient Safety Programme – Year One Update	**Director of Pharmacy & Medicines**					✓	

Ad Hoc Items (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Fife Specialist Palliative Care Services - Service Model	**Medical Director**					✓	
NHS Fife Response to the Ockenden Report	**Director of Nursing**						✓
Population Health & Wellbeing Strategy	**Director of Finance & Strategy**						✓
National Treatment Centre - Fife Orthopaedics	**Director of Estates & Facilities**						✓
Development Sessions							
	Lead						
Development Session 1 • E-Coli Bacteraemia • Cancer in Fife and NHS Fife's Cancer Framework	**Medical Director**				**01/11/22**		
Development Session 2 • Addiction Services • Medical Education	**Medical Director**						**12/04/23**

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**3 March 2023**
Title:	**Proposed Annual Workplan 2023/2024**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Shirley-Anne Savage, Associate Director of Quality and Clinical Governance**

1 Purpose

This is presented to the Clinical Governance Committee for:

- Decision

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper sets out the proposed Clinical Governance Committee (CGC) workplan for 2023/2024 and summaries the approach adopted to ensure there is a regular review of the workplan to enable the CGC to fulfil its remit. The proposed workplan was last presented to the Committee in January 2023 and is brought back for final approval.

2.2 Background

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

2.3 Assessment

The 2023/2024 proposed CGC workplan is attached in appendix 1 for consideration of the Committee. Updates to the workplan reflect the establishment of the new Medical Devices Group.

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

The proposed workplan for 2023/2024 has been developed in collaboration with Directors.

2.4 Recommendation

The Clinical Governance Committee is recommended to:

- Consider and approve the proposed workplan for 2023/2024; and
- Approve the approach to ensure that the workplan remains current

3 List of appendices

The following appendices are included with this report:

- Appendix 1- Clinical Governance Committee Workplan 2023/2024

Report Contact
Shirley-Anne Savage
Associate Director of Quality and Clinical Governance
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DRAFT CLINICAL GOVERNANCE COMMITTEE
PROPOSED ANNUAL WORKPLAN 2023 / 2024

Governance - General							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
TBC							
Governance Matters							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**						✓
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Director of Nursing**	✓ **Optimal Clinical Outcomes**	✓ **Quality & Safety**	✓ **Off-Site Area Sterilisation and Disinfection Unit Service**	✓ **Cyber Resilience**	✓	✓

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

Quality / Performance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
National Cervical Exclusion Audit	**Director of Public Health**		✓				
Safer Management of Controlled Drugs	**Director of Pharmacy & Medicines**				✓		
Covid Mortality Report	**Medical Director**	**TBC**					
Digital / Information							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Digital and Information Strategy Update	**Medical Director / Associate Director of Digital & Information**		✓			✓	
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Patient Experience (Safety & Quality of Care) – Lessons Learned	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓		

Annual Reports							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Adult Support & Protection Annual Report *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	✓					
Annual Resilience Report	**Medical Director**		✓				
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report	**Director of Pharmacy & Medicines**				✓		
Digital and Information Annual Report	**Associate Director of Digital & Information**	✓					
Director of Public Health Annual Report *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report	**Director of Nursing**					✓	
Fife Child Protection Annual Report	**Director of Nursing**	✓					
Health & Safety Subcommittee Annual Report	**Director of Property & Asset Management**	✓					✓
Hospital Standardised Mortality Ratio (HSMR) Update Report	**Medical Director**				✓		
IJB Quality & Communities Annual Report	**Medical Director**	✓					✓
Information Governance & Security Steering Group	**Associate Director of Digital & Information**	✓					✓
Integrated Screening Annual Report *(also goes to PHWC)*	**Director of Public Health**				✓		
Medical Education Report	**Medical Director**				✓		
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
Medical Devices Annual Report	**Medical Director**			✓			

Annual Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Nursing & Midwifery Annual Report	**Director of Nursing**	✓					✓
Occupational Health Annual Report 2022/23	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report	**Medical Director**						✓
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation *(also goes to PHWC)*	**Director of Nursing**				✓		
Prevention & Control of Infection Annual Report	**Director of Nursing**				✓		
Radiation Protection Annual Report	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Review of Deaths of Children & Young People	**Director of Nursing**						✓
For Assurance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Integrated Unscheduled Care Report	**Medical Director**	✓		✓		✓	
Linked Committee Minutes							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Clinical Forum	**Chair of Forum**	✓ 02/02 & 06/04	✓ 08/06	✓ 03/08	✓ 05/10	✓ 07/12	✓ 08/02

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Medical Committee	**Medical Director**	✓ 14/02	✓ 11/04	✓ 13/06	✓ 08/08	✓ 10/10	✓ 12/12
Area Radiation Protection Committee	**Medical Director**	31/08	TBC	TBC	TBC	TBC	TBC
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05		✓ 17/08	✓ 02/11	
Clinical Governance Oversight Group	**Medical Director**	✓ 14/02	✓ 18/04	✓ 20/06	✓ 22/08	✓ 24/10	✓ 12/12
Digital & Information Board	**Medical Director**	✓ 19/04		✓ 19/07		✓ 18/10	
Fife Area Drugs & Therapeutic Committee	**Medical Director**		✓ 26/04	✓ 21/06	✓ 16/08	✓ 21/10	✓ 20/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**	✓ 10/03	✓ 03/05	✓ 30/06	✓ 07/09	✓ 02/11	
Health & Safety Subcommittee	**Chair of Subcommittee**	✓ 10/03	✓ 09/06		✓ 08/09	✓ 08/12	
Infection Control Committee	**Director of Nursing**	✓ 05/04	✓ 07/06	✓ 09/08	✓ 04/10	✓ 06/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**	TBC	TBC	TBC	TBC	TBC	TBC
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 11/04		✓ 13/07	✓ 10/10		
NHS Fife Medical Devices Group	**Medical Director**	✓ 08/03	✓ 14/06		✓ 13/09	✓ 13/01	
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 27/03		✓ 21/06	✓ 19/09	✓ 11/12	
Resilience Forum	**Director of Public Health**	✓ 01/03		✓ 08/06	✓ 07/09	✓ 07/12	
Ad Hoc Items							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Mental Health Estates Initial Agreement	**Medical Director**	✓					

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

AREA CLINICAL FORUM (Meeting on 2 February 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Area Clinical Forum

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 2 FEBRUARY 2023 AT 2PM VIA MS TEAMS

Present:
Aileen Lawrie, Chair
Jackie Fearn, Consultant Clinical Psychologist
Robyn Gunn, Head of Laboratory Services *(items 1 – 7 only)*
Susannah Mitchell, General Practitioner
Janette Keenan, Director of Nursing
Amanda Wong, Director of Allied Health Professions

In Attendance:
Susan Fraser, Associate Director of Planning & Performance
Lynne Johnston, Service Manager *(item 6 only)*
Margo McGurk, Director of Finance & Strategy *(item 7 only)*
Joy Tomlinson, Director of Public Health *(item 5 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Donna Galloway (Women Children & Clinical Services General Manager). Ben Hannan (Director of Pharmacy & Medicines), Ailie Mackay (Speech and Language Therapy SLT Operational Lead), Paul Madill (Consultant in Public Health Medicine), Chris McKenna (Medical Director), Emma O'Keefe (Consultant in Dental Public Health) David Platt (Specsavers Optician) and Nicola Robertson (Associate 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 1 December 2022

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum noted the closed actions.

H Thomson to add to the action list: 'to raise the issue of the high level of abuse and hate crime that takes place at General Practitioners, on behalf of the ACF, at the Equality and Human Rights Strategy Group meeting on Friday 3 February 2023'.

Action: J Keenan

It was reported that a response will be provided from the Clinical Governance Committee, following the previous escalation, regarding the pressures being experienced by GP Practices to safely deliver care.

There were no matters arising.

5. Covid Enquiry

The Chair welcomed J Tomlinson to the meeting, who provided an overview on the Covid enquiry.

J Tomlinson advised that she is the single point of contact for NHS Fife, with the Central Legal Office Team, who are supporting all of the territorial Boards as one single team with Covid enquiries. Background to the Covid enquiry was provided, and it was advised that the Scottish enquiry began slightly earlier than the UK one. It was noted that Lord Brailsford is now the Scottish Covid enquiry Chair, replacing the Honourable Lady Poole.

The elements to the Scottish Covid enquiry was provided, which includes the public sector response, financial & welfare support to businesses and individuals, the vision of health & social care services, and education, certification and the impact on young people.

It was reported that the UK has structured three broad modules for the first stage, with it noted there are large legal teams involved. The modules underway, relative to Scotland, were described. J Tomlinson advised that all Scottish Health Boards will share the same legal team, and it was noted that other organisations can request to be core participants in the enquiry, which gives them access to the material being provided for the enquiry.

J Tomlinson advised that ongoing support is being provided, and helpful overviews have been provided on what enquiries are, the various stages, and what to expect. Following a question from the Chair, J Tomlinson confirmed that there will be communication sent out when module 3 stage commences.

J Keenan queried how fatal accident inquiries (FAI) will link into the Covid enquiry. It was advised that another enquiry called 'Operation Copper', for deaths in care homes and hospitals, that is being run by the Fiscals Office and in conjunction with Police Scotland, have been liaising with the Senior Lead Officer (SLO), who will advise Boards on how to engage with their requests.

S Mitchell questioned the process for gathering information from General Practices (GPs). In response, it was advised that this information has not been provided, with it noted that a strategic response is the focus of the Covid enquiry. It was also noted that the Operation Copper enquiry may be more relevant to gathering information from GPs.

The Chair thanked J Tomlinson for presenting.

6. Scottish Government Women's Plan

The Chair welcomed L Johnston, Service Manager to the meeting.

L Johnston presented on the Scottish Government Women's Plan, and provided a summary of progress since establishment of the Women's Health Plan Oversight Group, which included: menopause, endometriosis, post-natal contraception,

women's general health, early pregnancy loss and recurrent miscarriage, breastfeeding and mental wellbeing. The summary update will be shared with the Forum.

Action: H Thomson

S Mitchell highlighted that a GP representative is required on the Women's Health Plan Oversight Group. The Chair agreed to take this forward.

Action: A Lawrie

L Johnston provided an update on the developments of the gynaecology department.

S Mitchell highlighted the challenges for the GP team in regards to menopause prescribing, particularly to testosterone. It was advised the GP community are being asked to prescribe testosterone when women have attended specialist NHS menopause services and are having difficulty doing this as it is not on the current formulary. It was questioned if there is a need for a shared care protocol to be established. The Chair agreed to take this forward.

Action: A Lawrie

It was reported that a process for the menopause service is being set up to gather feedback.

It was agreed L Johnston will attend the Forum in a few months' time to provide a further update.

Action: H Thomson

7. Population Health & Wellbeing Strategy & Feedback from Questionnaire

The Chair welcomed S Fraser to the meeting.

S Fraser provided an overview of the Population Health & Wellbeing Strategy.

The Chair commented that the feedback received from the strategy questionnaire, via this Forum, highlighted the linkage between physical health not being separated from mental health, and questioned how this could be viewed. S Fraser noted that consideration will be given to deliver a more holistic approach to secondary care. S Mitchell highlighted the difficulties of having a holistic approach within General Practice. Suggestion was made to have quick wins, to encourage people to support the strategy. It was also noted that the strategy is very ambitious.

S Fraser advised that staff sessions will be carried out before the strategy is presented to the Board.

It was agreed a further update to provided to the Forum in a few months' time.

Action: H Thomson

8. GOVERNANCE MATTERS

8.1 Delivery of Annual Workplan 2022/23

The Forum noted the tracked workplan.

A timeline for the Scottish Government Rehabilitation Plan and Human & Equality Rights to be confirmed to H Thomson.

Action: A Wong/J Keenan

8.2 Proposed Annual Workplan 2023/24

Members to provide any additions / confirmation of timelines to H Thomson by mid-March, and an updated version will be presented at the April meeting for approval.

Action: Members

9. QUALITY / PERFORMANCE

9.1 Quality and Improvement Facility Updates

This item was not discussed.

10. UPDATES FROM EXTERNAL GROUPS

10.1 Area Clinical Forum Chairs Group for Scotland Update

This item was not discussed.

11. LINKED MINUTES

This item was not discussed.

11.1 General Practitioners Subcommittee held on 21 June 2022 (confirmed)
11.2 General Practitioners Subcommittee held on 16 August 2022 (confirmed)
11.3 General Practitioners Subcommittee held on 20 September 2022 (confirmed)
11.4 General Practitioners Subcommittee held on 18 October (confirmed)
11.5 General Practitioners Subcommittee held on 20 December 2022 (unconfirmed)

12. ESCALATION OF ITEMS TO THE CLINICAL GOVERNANCE COMMITTEE

There were no items to escalate to the Clinical Governance Committee.

13. ANY OTHER BUSINESS

<u>General Practices</u>

S Mitchell raised concern that there are two more General Practices (GPs) going back to the Board, due to the inability to recruit. It was also noted that three other GPs, which are run by the Board, are going out to tender.

14. DATE OF NEXT MEETING

The next meeting will take place on Thursday 6 April 2023 at 2pm via MS Teams.

AREA MEDICAL COMMITTEE (Meeting on 13 December 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

CONFIRMED NOTE OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 13 DECEMBER 2022 AT 2PM VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Marie Boilson	Clinical Director H&SCP
Phil Duthie	Associate Clinical Director H&SCP
Helen Hellewell	Deputy Medical Director, H&SCP
Fiona Henderson	Fife LMC Secretary
Iain MacLeod	Deputy Medical Director, ASD
Sally McCormack	AMD Emergency Care & Planned Care
Glyn McCrickard	Fife LMC Representative
Claire McIntosh	Chair, Division of Psychiatry
John Morrice	AMD Women & Children & Clinical Services
Susanna Galea Singer	Clinical Lead for Addiction Services & Clinical Innovation

In Attendance:

Maxine Michie	Deputy Director of Finance (for Item 5i)
Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Susie Mitchell, Joy Tomlinson, Morwenna Wood, Caroline Bates, Ian Fairbairn, Lynsey Rooney

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 11 OCTOBER 2022

The notes of the meeting held on 11 October 2022 were approved subject to the following amendment at Item 5iii – Medical Workforce – Paragraph 4 – last sentence to now read:
Several people will retire and return next year.

4 MATTERS ARISING

i) Adherence to Formulary

Dr McKenna has checked with Ben Hannan who has agreed to write to the Nurse Specialists (non prescribers) in relation to giving advice to GPs.

ii) Report from High Risk Pain Medicine Group

It was suggested one of the Leads of the Group would be asked to attend a Committee meeting to present their work.

iii) DNACPR position in Old Age Psychiatry

Dr Boilson has confirmed there are no significant issues.

iv) Date for Medical Staff Committee

To date there has been no progress in securing a date for the Medical Staff Committee to meet.

5 STANDING ITEMS

i) Financial Position

Maxine shared a presentation for the Committee.

A three-year financial plan was requested in August 2022 from the SGHD. A plan had already been completed in March 2022 for the current financial year of 2022-23 and a gap in funding had been identified of £10.4m. This was after a cost improvement programme of under £12m. The Plan was submitted to SGHD despite them wishing us to break even it was felt a cost improvement programme of around £22/23m was not achievable.

For the three-year plan assumptions were proposed with different scenarios; 2% uplift 1% uplift or flat line. It will not be clear until after the upcoming Budget what this will be. This also gives differing positions moving forward but based on a 2% uplift it would suggest we could get back to financial balance after three years. Anything less than 2% would take longer.

Assumptions had been made within the plan that included continued NRAC share which is overdue along with the PAG and reducing additional costs in relation to Covid to take forward an ambitious cost improvement programme. Delivering this is proving to be very challenging.

In August 2022, as reported in the IPQR, we are currently £14.5m overspent which is £10m adrift of our target. There is a planned gap with almost £4m unfunded Covid expenditure including the surge ward. Covid expenditure has also been cut by £7.5m which is a significant drop given the current challenges. Slippage is also included within the cost improvement plan along with activity for non-Fife healthcare providers and the general cost of living increases has also had a significant impact.

A deep dive was undertaken in August 2022 to ascertain what the position would be by the end of March 2023 and it is estimated that we would be £22m overspent if we do not take any further action. Of the £22m, £10.5m is approved. Surge bed costs are around £3m and conversations are underway with the H&SCP to acknowledge the pressures. All other savings plans are being looked at to see if they could be brought forward and maximise every opportunity. It has also been highlighted to SGHD that we are more likely to be around £16/17m overspent rather than £10.5m with the current continued surge / demand /capacity issues.

Allocations from SGHD has been uncertain all year as their position has been challenged.

In October 2022 the most current position is £17.5m overspend which is close to forecasted £22m. Conversations will continue with the SGHD, H&SCP to maximise very opportunity to reduce costs and make the best use of our finances. Whilst SGHD will step in to plug the gap at the end of the financial year this will have to be paid back within three years.

Dr McKenna highlighted the major issue is the non IJB delegated budget. The H&SCP position currently is they are significantly underspending and are forecasting to underspend by around £7m in March 2023. This is a unique situation as legislation allows them to carry forward underspend. This is not the position for Health. The total delegated budget is £7m with Health delegated budget is £1.7m underspent after we have already transferred over roughly £3/4m to the H&SCP.

Work will continue with H&SCP colleagues to support this year and how we work to take pressures from the front door going forward.

In taking comments the Committee noted the situation is complicated and challenging and work has been undertaken and will continue to face the challenges and seek opportunities to do things differently and more efficiently. There is also the need to change the culture of our citizens and how they access services, and this will be part of the Clinical Strategy over the next few years.

Dr McKenna thanked Maxine Michie for her update.

The Committee is asked to share the update and challenges with their Teams.

ii) Medicines

Dr McKenna advised there is an overspend within Acute which is largely driven by inflation and new drugs rather than non-compliance with Formulary.

iii) Adverse Events Update

Dr McKenna advised he has asked for a deep dive for some of the adverse events as there is a trend in increasing major and extreme events. This may be the result of current pressures across services. One area of concern is cardiac arrests and work is underway to restart Gavin Simpson's previous work.

iv) Medical Staff Committee

As discussed above.

v) Update from GP Sub Committee

Fiona Henderson there was no update other than primary care are experiencing the same pressures as secondary care.

In relation to Strep A Dr McKenna said he has been seeking Guidance from the CMO who has advised Scotland will adopt the NHS England Guidance which is currently online. Dr Morrice confirmed this has been shared with paediatric colleagues. Dr McKenna shared the links for the NHS England Guidance and Royal College to the chat and suggested Dr Hellewell may wish to circulate to GPs advising this will be endorsed by SGHD in due course.

Dr McCormack said she was aware of feedback around some unhappiness concerning the Flow and Navigation hub. Dr McKenna advised he was aware of the issues as he sits on the GP Sub Committee. In discussion Fiona Henderson expressed her concerns. Dr McCormack said it is good to hear the concerns as it did show things were being diverted but agreed the issues do need to be fixed. Dr McKenna advised that he, Claire Dobson and Nicky Connor will consider how to find another way of doing things and provide an update at the next meeting.

vi) Realistic Medicine

There was no specific update. Dr McKenna said the Realistic Medicine Team will be asked to attend a future meeting and provide an update.

vii) Medical Workforce

Dr McKenna agreed to reissue the Circular in relation to the new SAS Doctor Contract. In giving an update Dr McKenna advised Associate Specialists still exist within our workforce and if they had been part of the workforce before the grade was removed, they would likely stay Associate Specialists. There are now two new grades of doctor called Specialist Doctor and Specialty Doctors. There are two grades and the new grade of Specialist Doctor is yet to be confirmed how we will recruit into. There is a new contract associated with this job and current Associate Specialists can move over into this contract. Specialty Doctors also have a new contract and they can move over to the new contract as well.

There are two major issues with the Speciality Doctor contract; one in relation to Job Planning and no more than one third of their Job Plan can be Out of Hours unless there is a preferential agreement to do so. This is a big change as some services rely on this grade of doctor to provide out of hours cover so this will have an impact on Job Planning and service provision. The other is relation to the new pay scales; while the top of the pay scale has not moved much the bottom has which will result in financial implications. A piece of work is underway to understand the financial implications of moving doctors across to the new contract will be.

In taking comment it was noted the difficult situation within the mental health workforce. It is hoped the new Specialty Doctor grade should help recruit and retain.

Dr McCormack advised five Gateway doctors have started at FY1 equivalent. These doctors will do up to a year as an FY1 and then up to an FY2 and if all goes well consideration will be given to where they can be placed. Professor Wood is the Educational Supervisor for all five and there has been positive feedback. They do not have to do a full year at FY1 if they are deemed competent by Professor Wood as they already had full registration. This is an answer to some of the problems within Fife as we do not get enough trainees

Dr McKenna highlighted Medical Workforce needs to be included within our Strategy across all services. There is an opportunity around using Physician Assistants to a create workforce.

viii) Education & Training

Professor Wood was not present to provide an update.

Dr McKenna highlighted FY experience in Scotland is one of the worst in the UK and this is shown through the GMC questionnaire. Emma Watson, newly appointed Medical Director of NES, will be taking a new approach will be different given her Director of Medical Education background rather than Post Graduate Dean.

There was discussion around the issues being faced with trainees and the current culture. It was agreed a lot of work is required to change this and there is a willingness to listen.

6 STRATEGIC ITEMS

i) Update from Health & Well Being Portfolio Board

Dr McKenna did not attend the last meeting so was unable to provide an update.

ii) GMS Implementation

Dr Hellewell advised the Government has taken back some of the underspend but some of it will need to be used to cover the commitments already made by the H&SCP as the Primary Care Improvement Fund did not receive their full allocation. There is now the issue, even if the money had been received, the difficulties with recruiting and the ability to fill posts.

Dr McKenna agreed this was a complex situation for secondary care colleagues and noted the challenges being faced.

iii) COVID & Remobilisation

It was agreed this item can be removed as a standing item on the agenda.

Although not for this Committee Dr MacLeod agreed to discuss with Claire Dobson and Infection Control beginning to return to our original pre Covid footprint.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee held on: 20 September 2022

Noted

ii) Notes of the Clinical Governance Oversight Group: 16 August 2022

Noted

iii) Notes of the NHS Fife Area Drugs & Therapeutics Committee: 12 October 2022

Noted

8 AOCB

Susanna Galea Singer gave an update on the following Innovation work:

Reducing Drug Death Challenge

Following a UK wide call NHS Fife put in a bid and were successful so will be undertaking collaborative work with England, Wales and Northern Ireland.

Mental Health Challenge

Borders put out a call for a Mental Health Challenge. NHS Fife are part of Regional Group named Health Innovation South East Scotland looking at the possibility of applying artificial intelligence to improve the way in which young people engage with Mental Health Services.

Innovation Fellowship

A Senior Physio applied for Fellowship and was successful (baby hip).

Innovation Scouts
Innovation Scouts will be available within NHS Fife to foster innovative thinking on the shop floor.

9 DATE OF NEXT MEETING
Tuesday 14 February 2023 at 2pm via MS Teams

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (Meeting on 13 January 2023)
No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 14:00 on Friday 13th January 2023 via Microsoft Teams

Present:	**Designation:**
Izzy Corbain (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Fiona Forrest (FF)	Deputy Director of Pharmacy
Alistair Graham (AG)	Associate Director Digital and Information
Nick Haldane (NH)	Lead Cancer GP
Jennifer Leiper (JL)	Patient Representative
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
John Robertson (JR)	Lead Cancer Clinician - Surgery
Nicola Robertson (NR)	Associate Director of Nursing, NHS Fife
Shirley-Anne Savage (SAS)	Associate Director of Quality and Clinical Governance
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 - Public Health
Nicky Connor (NC)	Director Health and Social Care
Susan Fraser (SF)	Associate Director of Planning & Performance
Ben Hannan (BH)	Director of Pharmacy & Medicines
Janette Keenan (JK)	Director of Nursing
Murdina MacDonald (MM)	Lead Cancer Nurse
Rishma Maini (RM)	Consultant - Public Health
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Chris Cartlidge (CC)	Consultant – Breast Surgery

		Action
	Welcome	
	CM welcomed everyone to the meeting.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 19 August 2022 via Microsoft Teams**	
	The Unconfirmed Note of 19 August 2022 was **accepted** as an accurate record.	
3.	**Matter Arising/Action list**	

		Action
	020622#1 – This action is around a paper that BH brought to the cancer ops group in relation to the letter in regard to the National Oncology Taskforce. CD advised BH has agreed to share this paper with this group. CD to send paper to RH. Action can be closed. 190822#2 – Action to be closed. 190822#3 – Action to be closed. 190822#4 – Action to be closed. 041122#5 – Action to be closed. 041122#6 – Meeting to be set up. Action to be carried forward. 041122#7 – Action to be closed. 041122#8 – KN and CD still to discuss and will confirm at the next meeting. 041122#9 – Action to be closed.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group**	
	Item to be carried forward to the next meeting.	
4.2	**Cancer Risks**	
	One new risk has been added in relation to cellular pathology scientific/ technical staffing, and one risk has been removed in relation to histology wax supply issues. It remains as 7 high risks and 4 moderate risks. 3 risks are currently overdue and 4 are due for review. There is still to be an agreement on which risk they will undertake a deep dive on. This will be agreed at the Acute Cancer Services Delivery Group. A meeting is to be set up to clarify the purpose of the risks coming to the meeting and what they want that to look like.	**RH**
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Approval Update**	
	The Cancer Framework went to the Clinical Governance Committee and was well received. They agreed at the Clinical Governance Committee that they will take it to the board. It was noted that before it is published, it needs proof reading. KN	

		Action
	advised that SAS and E Muir have agreed to proof read. Once this has been completed the Cancer Framework will be presented to NHS Fife Board	
5.2	**Cancer Framework Annual Delivery Plan Overview 2022-23**	
	In the Cancer Framework Annual Delivery plan for 2022-23 there are 40 objectives that were agreed across all 8 commitments. 11 of these are complete, for example: • Patient's representation on cancer groups • Launch of SPOCH • Delivered the Prehabilitation in Maggie's 23 are in progress and are on target to be delivered by March 23, for example: • Expansion of RCDS • Scoping of community pharmacy USC referrals • Expand Care Opinion across cancer sites • Patient evaluation of SPOCH • Best supportive cancer pathway KN advised they are awaiting an update on 5 of the actions from Public Health. 2 have not yet started: • The concept of a delivering cancer unit in Fife. They are aiming to set up a SLWG. Some of this links in with ongoing ambulatory work and outcome of ECC reprovision initial agreement. • Reviewing delivery of non SACT interventions. This has not started due to current workforce pressures in pharmacy and SACT. There are some actions that progressing well but they will roll over to 2023, for example: • Cancer tracking system. • Prostate and lung pathway reviews.	
5.3	**Cancer Framework Annual Delivery Plan 2023-24**	
	It was agreed that they would review the cancer framework delivery plan on a yearly basis. KN advised they will do this similar to last year and send out the template widely to collate everyone's priorities. It is expected that any priorities identified by services should align with the Cancer Framework commitments. CM asked if before this is sent out, think about how it is delegated through this group down into the operational cancer group.	

		Action
	KN and SF to discuss this along with ensuring any priorities align with SPRA. CM advised what is needed is a report of where we are at with the 2022-23, and what the plan is for 2023-24. This will then give assurance to this group. KN to provide an update on actions for the March Clinical Governance Committee It was noted that a yearly update on the framework may need to go to the Clinical Governance Committee to provide assurance. CM advised that this should be done at the first quarter of every year. SF advised any exception reporting should also be included.	**KN**
5.4	**10 Year Cancer Strategy and Action Plan**	
	This has come through via SCAN and an update needs to be provided by Monday the 16th of January. This has been sent to group to ask for comment. Some comments have been returned and others are to be sent on. All the comments will be collated and sent to SCAN.	
5.5	**Rapid Cancer Diagnosis Service – Community Pharmacy**	
	FF advised the paper that has come to the group today is seeking approval for the project in principal to proceed to the next stage. This paper proposes the development of a “safety bundle” and “screening intervention” within CPs that would highlight people at greater risk of suspected Lung, Head and Neck cancers for quicker and more direct referral which would be piloted within identified Community Pharmacies in NHS Fife. This proposal has been through a number of different groups. CM agreed to this proposal.	
6.	**FUNDING**	
6.1	**Funding Governance Process**	
	At the last meeting KN and CD agreed to review the process and make minor tweaks. This has been done and is being brought back to the group. This process is to ensure there is a governance in place so that any requests for funding which may be recurring or non-recurring are agreed and supported appropriately, that they align to the Cancer Framework key priorities and that this process ensures fair and equitable access. The flowchart will be widely circulated across the organisation.	**KN**
6.2	**Optimal Lung Cancer Pathway Funding Update**	
	The Optimal Lung Cancer Pathway was published recently and comes with a toolkit to support implementation and funding of £3m for 2022-23.	

		Action
	A group has been set to look at what we are currently doing, what we can do, what we can't do, and what resources we need. They are currently collecting baseline information from radiology, CWT and QPI data. Alongside this it's provided an opportunity to simultaneously undertake some pathway improvement work: • Exploration of changes to improve current pathway which would be cost-neutral – changing investigation days, moving clinics to reduce days to MDT. • SPOCH are looking to support radiology initiating with pathway to minimise wasted CT slots. • Looking at waits from GP referral to CXR to CXR. GPs can access same day/next day films where there is a suspicion. The Service Manager is looking at if there is anything they can put forward for 2022-23, to follow on to 2023-24 – this is currently being worked up and put through the governance process which has now been approved. They are also working with SCAN and a meeting has been organised.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times**	
7.1.1	**Quarter 3 2022**	
	NHS Scotland 62 day performance 74.4% (76.3% previous quarter and 83.7% in Q4 2019). There was an increase of 2.2% eligible patients compared to the previous quarter and an 11.8% increase compared to Q4 2019. NHS Fife achieved 81.4%, which is above the Scotland average. Urgent suspected referrals continue to exceed pre-COVID levels. NHS Scotland 31 day performance was also not met achieving 94.3% (95.5% previous quarter and 96.5% Q4 2019). There was an increase of 1.2% eligible patient compared to the previous quarter). NHS Fife met the target with 96.8%. The report shows that there are now a higher number of adjustments for social and medical delays being made. For the unadjusted 62 day performance: Scotland: 55.6%, Fife: 62.8%,	

		Action
	and for the unadjusted 31 day performance: Scotland: 88.1%, Fife: 90.4%. Prostate is our most challenged pathway with an average of 34% of patient being treated in the 62 day standard over a 3 month period. Reasons for breach are attributed to annual leave, sickness and vacancy, theatre capacity due to introduction of robot and increased referrals in Fife. FDG shortage for PET, turnaround times for molecular testing carried out in other Boards has also impacted on our performance. Pathways continue to be very challenged despite what we do to prioritise cancer. There is a group set up to review the D&D manual, which was published 2009. It's felt it's not fit for purpose (WTAs not patient friendly, they are looking to learn from NHSE data and definitions).	
7.2	**Quality Performance Indicators**	
7.2.1	**Breast 2021**	
	CC went through the papers that were shared with the group. Case ascertainment for NHS Fife is **103.5%** NHS Fife met **8** of the 18 (including sub QPIs) QPIs for Breast cancer, with no applicable patients falling under one QPI. **QPIs Not Met:** • **QPI 6 (i) *Immediate Reconstruction Rate*:** 41 patients did not have immediate reconstruction. The main reasons were: patient choice; the potential for post-mastectomy radiotherapy; co-morbidities/risk; and smoking history. The patient not recorded for the denominator was at time of analysis receiving adjuvant chemotherapy prior to being considered for further surgery. The patient not recorded for exclusion had an indeterminate pulmonary nodule therefore M staging remained unrecorded. • **QPI 9 *HER2 Status for Decision Making*:** In 21 cases the patient did not have their HER2 status reported within 14 days. Of these, 17 were delayed due to the need for FISH analysis and in 1 case a HER2 test was performed on the surgical specimen rather than a biopsy. For the remaining 3 there was a delay in the sample initially being sent to Lothian which meant the overall timeframe exceeded 2 weeks. The change in practice introduced in Fife in late 2020 has helped improve the results for 2021. • **QPI 11(ii) *Adjuvant Chemotherapy*:** 7 patients covered by the QPI did not undergo adjuvant chemotherapy: 4 declined chemo; 2 had co-morbidities; and in 1 case the reason was a clinical decision coupled with the patient's preference not to have chemo. • **QPI 13 *Re-excision Rates*:** In each of the 27 cases there were positive margins following the first surgical procedure.	

		Action
	• **QPI 14(ii)** ***Referral for Genetics Testing (triple negative <50 years of age)*****:** 1 patient was not referred for genetic testing. This patient, although diagnosed in Fife, moved to Ayrshire & Arran after their initial biopsy so all further investigations and treatment were carried out there. NHS Ayrshire & Arran did not refer the patient for genetic testing and declined to record the patient in their audit. • **QPI 16** ***Clinical Trials and Research Study Access*****:** Fife did not meet the target. • **QPI 17** ***Genomic Testing*****:** 1 patient was not suitable for chemo, 1 did not wish to pursue it so no genomic tests were performed, and 1 patient refused the test. • **QPI 18(i)** ***Neoadjuvant Chemotherapy*****:** 6 patients covered by the QPI did not undergo neoadjuvant chemotherapy. 5 were considered for it at the MDT or the oncology clinic but proceeded straight to surgery due to poor fitness/co-morbidities/high risk. 1 patient was given a cancellation slot for surgery, which was done prior to her (positive) HER2 status being reviewed at the MDT. The patient not recorded for the denominator had an indeterminate spinal lesion therefore M staging was not recorded. • **QPI 19** ***Deep Inspiratory Breath Hold (DIBH) Radiotherapy*****:** All radiotherapy for Fife patients takes place in Lothian and it is noted that the figures for this QPI have improved from 2020. At the time of analysis, confirmation of DIBH technique was only available for patients who had commenced their radiotherapy treatment up to the end of July 2022 and 1 patient treated after this date was included in the denominator but not recorded for the numerator. There were no specific individual actions identified for NHS Fife.	
7.2.2	**Colorectal 2020-21**	
	JR went through the papers that were shared with the group. Case ascertainment for NHS Fife is **80.2%** In NHS Fife **267** patients (266 previous cohort) were diagnosed with colorectal cancer (195 colon cancer and 72 rectal cancer). NHS Fife met **21** of the **23** (including sub-QPIs) QPIs for colorectal cancer. Reasons are for not meeting the QPI are documented within the report. **QPIs Not Met:** • **QPI 12ii** *30 Day Mortality Following Palliative Chemotherapy* – This QPI was not met with a shortfall of 4.3% (1 case). The patient was very frail with advancing disease. • **QPI 13** *Clinical Trial and Research Study Access* – Clinical Trials were not actively recruiting for most of the year due to the Covid-19 pandemic.	

		Action
	There were no actions identified for NHS Fife.	
8.	**LINKED COMMITTEE MINUTES**	
8.1	**Cancer Managers' Forum (14/10/2022)**	
	This was noted by the group.	
8.2	**Acute Cancer Services Delivery Group (25/11/2022)**	
	This was noted by the group.	
8.3	**Cancer Leadership Team (25/10/2022 and 20/12/2022)**	
	This was noted by the group.	
8.4	**Rapid Cancer Diagnostic Services Oversight Group (29/09/2022)**	
	This was noted by the group.	
8.4	**Earlier Cancer Diagnosis Programme Board (15/11/2022)**	
	This was noted by the group.	
8.5	**Cancer Delivery Board (05/10/2022)**	
	This was noted by the group.	
8.7	**Regional Cancer Strategy Group (06/12/2022)**	
	This was noted by the group.	
9.	**Items to Note**	
	No items to note	
10.	**ISSUES TO BE ESCALATED**	
	No issues to be escalated. Assurance will be given at the next Clinical Governance Committee around the plans for updating the Committee in regard to the Annual Delivery Plan for the Cancer Framework.	
11.	**ANY OTHER BUSINESS**	
	No Any Other Business	
12.	**Date of Next Meeting:**	
	The next meeting will be on Thursday 30 March 2023, 2pm – 4pm via MS Teams	

NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 20 December 2022)
No issues were raised for escalation to the Clinical Governance Committee.

NHS Fife Clinical Governance Oversight Group

Date: 20/12/2022
Enquiries to: Rebecca Hands
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 20 DECEMBER 2022 AT 15.00 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Associate Director of Nursing, HSCP
Norma Beveridge (NB)	Interim Associate Director of Nursing, Acute
Lynn Campbell (LC)	Associate Director of Nursing, Acute
Pauline Cumming (PC)	Risk Manager
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Dr Helen Hellewell (HH)	Associate Medical Director, HSCP
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Janette Keenan (JK)	Director of Nursing
Aileen Lawrie (AL)	Associate Director of Midwifery
Dr Iain MacLeod (IM)	Deputy Medical Director, Acute
Sally McCormack (SMcC)	Associate Medical Director for Emergency Care and Planned Care
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Dr John Morrice (JM)	Associate Medical Director of Woman & Children
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Shirley-Anne Savage (SAS)	Associate Director of Quality & Clinical Governance
Amanda Wong (AW)	Director of Allied Health Professions

In attendance

Shona Adam (SA)	Head of Nursing, HSCP
Rebecca Hands (RH) (minute taker)	Clinical Governance Administrator

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Benjamin Hannan (BH)	Director of Pharmacy & Medicines
Sally O'Brien (SO'B)	Head of Nursing, Fife HSCP, Nursing Directorate
Siobhan McIlroy (SM)	Head of Patient Experience
Nicola Robertson (NR)	Associate Director of Nursing, Corporate Division
Geraldine Smith (GS)	Lead Pharmacist, Medicines Governance
Prof Morwenna Wood (MW)	Consultant Nephrologist – Renal Medicine

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 18th October 2022**	
	The Group confirmed that the note from the meeting held on the 18th of October 2022, was a true reflection of what was discussed.	
3	**Matters Arising/Action List**	
	Action Ref 9 (Patient Experience) – This action will be discussed under the	

	appropriate agenda item. Action Ref 4.2 (NHS Fife Activity Tracker) – This was taken offline and can now be closed. Action Ref 5.1 (Clinical Governance Framework) – This action will be discussed under the appropriate agenda item. Action Ref 6.2 (Deteriorating Patients) – A working group has been set up so this can now be closed. Action Ref 6.2 (Resuscitation Committee) – A Resuscitation Committee meeting was set up so this can now be closed.	

4	**GOVERNANCE**	
4.1	NHS Fife Clinical Policy & Procedure Update **(EM)**	
	EM advised at their October 2022 meeting, the NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group approved one new policy and one new Acute Services Division (ASD) policy. As an organisation, we now have 94 clinical policies and procedures. The two new policies that were approved at the October meeting were: • OTD-01 - NHS Fife Wide Organ and Tissue Donation Policy • NMABC-01 - Acute Services Division for Non-Medical Authorisation of Blood Components Policy At the October meeting one policy, two Fife wide procedures, and one ASD procedure were past their review date. However, following on from the December 2022 meeting, only one Fife wide procedure and one ASD procedure are out of date. The group were given assurance that there is a 96% compliance rate for all NHS Fife clinical policies and procedures.	
4.2	NHS Fife Activity Tracker **(EM)**	
	EM advised the update for the NHS Fife Activity Tracker is in relation to Scottish Health Technologies which is an agenda item. This item will be discussed under item 4.5.	
4.3	Corporate Risk Register **(PC)**	
	PC advised that the process of reviewing and updating the corporate risks in preparation for the January 2023 Governance Committees is currently underway. The first cycle of reporting on these risks to the Governance Committees was in November 2022. There will be refinements and iterations as we go forward. It was noted that the committees will consider deep dive reviews of their aligned corporate risks over the next few months. The format of the deep dive	

	review is still evolving.	
4.4	E-Coli / Cauti **(SA)**	
	SA advised this paper has been brought to this group to advise of a change in process in relation to the reporting of all Ecoli Bacteraemia (ECB) infections. The new process of carrying out a Complex Care Review (CCR) will ensure that the teams are supported to review infections using a standardised template with Multi Disciplinary Team input involving a Microbiologist, Infection Control Nurses and a nurse from the Bowel and Bladder service. Enhanced surveillance on all Catheter related Urinary Tract Infections (CAUTI) related to ECB will be undertaken through the proposed CCR process. Key stakeholders have been involved in a number of meetings to ensure that the CCR process and tools are fit for purpose for the clinical teams and to provide assurance. All ECB infections will be reported in Datix by the Infection prevention and control team. The Team Leader or Senior Charge Nurse will then investigate and complete a CCR. This is to ensure the correct procedure/process has been followed and to ensure a consistent approach in the management of catheters across NHS Fife. To assist in the completion of the CCR it is recommended that the investigator of the CCR discusses the findings with an appointed advisor from the membership of Urinary Catheter Improvement Group (UCIG). The completion of a CCR will ensure the following: • Standardised approach to reporting. • An in depth review of each infection that is reported through Datix. • Advice and guidance will be provided by subject matter experts. • Provision of valuable learning that will improve practice. • Enable any learning opportunities or variation in care to be identified which can then be fed back to the UCIG. • This in turn will allow for the development of new procedures and processes to reduce CAUTI related ECB Infections.	
4.5	Scottish Health Technology Group Quarterly Bulletin 2022 and Risk Assessment **(CMcK)**	
	EM advised within the bulletin highlighted in red, are a number of Scottish Health Technology Group assessments that all boards in Scotland are being asked to consider. The ask here is because we don't have anything currently in place, how do we give assurance that things have been looked at within our services and reported back on. EM asked do we share these with the appropriate Clinical Directors and Heads of Nursing to share with their services to review and to feedback through their appropriate committees. CMcK advised this is something for NHS Scotland to consider and not individual boards. EM advised what they will do is keep a database of everything that comes in and date of receipt so that we have a record if a 'look back' is necessary. CMcK asked IMcL to look at this and advise where this should sit and to come back with a proposal.	**IMcL**

	EM to go back to HIS to find out what is required of the Board when this information comes in. This will be brought back to the next meeting.	**EM**
4.6	Deteriorating Patient Improvement Plan **(IMcL)**	
	IMcL advised this is work looking at deteriorating patients which is being led by Gavin Simpson and EM. They have a met a few times to discuss a framework and a process of how they are going to address the deteriorating patient within acute services. LC advised they have a chance to run a test which would mean the observations taken would go into Patientrack quicker. They have the basic kit to run a test and there is a significant amount of staff time to be saved if this works out how as predicted.. This would also help out with the obs on time. CG advised they have some improvement work being carried out in the HSCP. The improvement plan that is being worked on will be going to the NHS Fife Deteriorating Patient Group in January 2023 to get agreement and to get people on board to progress some actions. EM advised that Gavin Simpson will be attending the next meeting in February 2023 to discuss the Q2 report and to present the improvement plan. CMcK advised somebody had switched off the alerts for Patientrack at the beginning of the pandemic and they were not switched back on again. The governance for that decision is unclear as it did not go through CMcK. CMcK asked if any of the group knew what happened, and asked if anyone can work out why that happened. IMcL and NB are looking into this and are liaising with Gavin Simpson.	
4.7	Organisational Learning Group **(NR)**	
	IMcL advised they have had discussions in regard to re-examining the purpose of the Organisational Learning Group, expected outputs and where it fits in to the Governance structure of the organisation. There is ongoing work in regard to this.	
4.8	5 Year Synopsis on Significant Adverse Events Review / Local Adverse Events Review **(CF)**	
	This report provides a 5 year synopsis of the number of adverse events in particular incidents with major or extreme outcomes in terms of harm that have had a significant or local adverse event review (SAER/LAER) commissioned. NHS Fife reports and manages major and extreme adverse events in accordance with Learning from adverse events through reporting and review: A national framework for Scotland: December 2019. During the peak of the Covid Pandemic there have been 2 periods of pause on SAER and LAER activity in response to the priorities of and clinical pressures on services. The 2 pauses combined represent a 6 month pause on SAER activity and 8 month pause on LAER activity. There were no alterations to	

	national guidance at this time, expectations of completion of SAER/LAER reviews remained at 90 days. The accumulation of open SAERs/LAERs on top of a slight increase in numbers of newly commissioned SAERs/LAERs is presenting as significantly challenging to manage by services that are already under pressure. There is a risk that learning is not being identified and acted on timely, with SAER reviews exceeding the 90 day expected completion time. E-learning (TURAS) for managing a SAER/LAER was launched in November 2022. The addition of this educational material creates the opportunity for increased numbers of trained lead reviewers across the organisation. Development of the Adverse Event Policy and process due in January 2023 should offer the opportunity for a more streamlined and efficient management of major and extreme adverse events. There is a need to explore options to resource the management of the backlog of SAERs.	
4.9	Membership Discussion **(CMcK)**	
	CG asked if they can look into reviewing the membership as the group has evolved. LB advised a general manager from the partnership used to sit on the group. LB asked if the membership will be extended out to heads of service. SAS advised the concern about extending the membership would be about how big the group would get as where would it stop in terms of general managers and heads of service for different areas. SMcC advised that they expect the clinical leads to attend the ASD Clinical Governance Committee and at the moment they are stretched at the moment. CMcK noted the management representation isn't here and has slipped off. ToR to be reviewed by CMcK.	
5	**STRATEGY/PLANNING**	
5.1	Clinical Governance Framework **(SAS)**	
	SAS advised they are almost finished finalising the Framework. This was presented to this group on the 18th of October 2022 and was presented at the Clinical Governance Committee on the 4th of November 2022. There were various comments from EDG and committee members. These comments have been taken on board. This will be going to the Clinical Governance Committee for approval in January 2023.	
6	**QUALITY/PERFORMANCE**	
6.1	NHS Fife Integrated Performance & Quality Report (IPQR) September/October 2022 **(CMcK)**	

	JK advised following the work that has been going on and the way that they are capturing the information, they are sitting on 56% for complaints. There will be patient experience reports going to EDG at the beginning of January 2023 for the Clinical Governance Committee. CMcK advised in regard to HSMR, the calculation is based on deaths within 30 days of discharge. Patients who are discharged on an end of life pathway with palliative care who die within 30 days are put toward the figures. CMcK advised they would need to have a conversation with Public Health Scotland about how they can be factored in as they really should not be considered within the data as it is not a poor outcome. LC advised that in regard to falls, it needs to be looked at over a period of time because it does fluctuate.	

7	**Adverse Events & Duty of Candour Status Update**	
7.1	Adverse Events KPIs and Incident Flashcards **(CF)**	
	CF advised the numbers in the top 10 categories have not changed in the past few months. There has been a delay in receiving SBARS causing a backlog, along with a delay in closing actions and closing SAERs and LAERs.	
7.2	Organisational Duty of Candour Report **(CF)**	
	CF advised there were 29 activations for the financial year to date. The most reported category for duty of candour is tissue viability which is 12 of the 29. The most common outcome is increase in treatment which is 19 of the 29.	

8	**Adverse Events Improvement Work**	
8.1	Adverse Events Improvement Plan **(CF)**	
	CF advised the next key steps in the improvement plan • Introduction of new report templates for SAER, LAER and CCR from 9th January 2023. • Introduction of a new review commissioning process for major and extreme events. The new process due to commence on 9th January sees greater responsibility for decision making, on the level of review, remaining at services level involving the senior multi-disciplinary teams. The service will be responsible for the commissioning of LAER or decision for the event to be downgraded. Decisions for SAER will be escalated to the executive team for agreement. CF advised that Acute and Corporate services have not finalised their process therefore only HSCP will commence with the new process on 9th January 2023.	

	CF and SAS will work with Acute and Corporate Services colleagues to finalise process with a view to commencing on 1st March 2023.	
8.2	NHS Fife Adverse Events Policy **(CF)**	
	The decision was taken at this group that they can split the Adverse Events Policy into two separate documents. One is the policy which outlines the 'why' they need to do it and the national governance and framework around it. The second document is around the' how ' they do it which is very much procedural guidance. There will be a resource pack which will go alongside it.	
9	**PATIENT EXPERIENCE**	
9.1	Patient Experience Flash Card December 2022 - C/F from 18 October 2022 **(SM)**	
	JK advised the patient experience flashcard that has been sent with the papers is the first version and has since been changed. JK shared the patient experience flashcard with the group. The flashcard highlights the number of complaints coming in along with the positive and negative themes.	
10	**LINKED COMMITTEE MINUTES**	
10.1	NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group 24th October 2022 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.2	NHS Fife In Patient Falls Steering Group 10th November 2022 **(LC)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.3	NHS Fife Resuscitation Committee on 11th November 2022 **(CMcK)**	
	There are concerns over the BLS training programme across the whole organisation. NR is working on a proposal at the moment around how to manage some of this.	
10.4	NHS Fife Point of Care Testing Committee 7th December 2022 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.5	NHS Fife Organisational Learning Group 31st October 2022 **(CF)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.6	NHS Fife Adverse Events Local Network Group 23rd November 2022 **(CF)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	

11	**ITEMS TO NOTE**	
11.1	NHS Fife Clinical Governance Oversight Meeting Dates 2023	
	This was noted by the group.	
12	**ISSUES TO BE ESCALATED**	
	The final version Clinical Governance Framework will be taken to the Clinical Governance Committee on 13 January 2023. Any issues in relation to adverse events and deteriorating patients will be contained with the update within the IPQR.	
13	**ANY OTHER BUSINESS**	
	No Other Competent Business.	
	Date of Next Meeting 14th February 2023 09:30 via Microsoft Teams	

DIGITAL AND INFORMATION BOARD

(Meeting on 24 January 2023)

LIMS escalated to Clinical Governance Committee
(Item confirmed on CCG workplan 23/24)

Digital and Information Board

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON TUESDAY 24TH JANUARY 2023, 1100, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
Rachel Heagney	Head of Improvement, Transformation & PMO on behalf of Director Health & Social Care
Maxine Michie	Deputy Director of Finance on behalf of Director of Finance & Strategy
Claire Dobson	Director of Acute Services
John Chalmers	Clinical Lead, Digital & Information
Sharon Mullan	General Practitioner
David Miller	Director of Workforce
Caroline Somerville	Partnership Representative
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:	
Andy Brown	Principal Auditor
Lynn Barker	Director of Nursing
Marie Richmond	Head of Digital Strategic Delivery, Digital & Information
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Charlie Anderson	Head of ICT, Fife Council
Allan Young	Head of Digital Operations, Digital & Information
Miriam Watts	General Manager, Emergency Care
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Shelley Marshall	Head of Business and Resource, Digital & Information
Apologies:	
Margaret Guthrie	Head of Information Governance & Security / DPO
Amanda Wong	Associate Director, AHPs
Janette Keenan	Director of Nursing
Joy Tomlinson	Director of Public Health
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 noted there have been changes to the attendance, a round of introductions were made. Apologies were noted to the Board.	
2	**MINUTE & ACTIONS OF MEETING HELD – 18/10/22**	
	Minutes were reviewed and a query was raised re item 6.3 Strategy Update, Digital First. Clarification and update to minute required. **Action CN – CN to confirm wording**	**CN**
3	**MATTERS ARISING**	
	3.1 Critical Incident Update A Young advised they have brought this item to the Board for awareness and to provide a verbal update on the 3 critical incidents that occurred last year:	

	Docman Incident - This occurred in May 22, where it was discovered, documents were missing, and concerns were raised this may have caused harm to patients. An investigation was undertaken, and clinical review of documents done for assurance. Upon this investigation, confirmation was received there was no harm to patients and around 463 documents were missing with a possible further 40 to be added with one GP Practice to be completed. This was reported as a category 3 incident, potential harm to patients. A submission was presented to the ICO, and they are currently awaiting the outcome. A query was raised what the likely outcome might be? A Graham replied ICO would consider the impact and it is likely to be confirmed as no further follow up. A Young advised this was a national incident and there were consultations with the supplier. A patch how now been applied, reviewed, and assured the documents are now going where they should be. Dr McKenna raised a query with steps that have been done to ensure this doesn't happen again. A Young advised the supplier now has a tool and this is being regularly checked. A Young acknowledged the amount of work that some of the GP Practices may have had. S Mullan noted through their practice checks no patients had been adversely affected and there was no mention of negative impact from other GP practices. **Adastra OOH** - This occurred last year with a cyber-attack. This has now been recovered and assurances received through NSS. Adastra Laptops were replaced at the time of the incident. Follow up to see what the best arrangement is needed for OOH service. **Carestream** - An incident occurred on 11th January, where the system was unavailable for around 13 hours. Investigations with the supplier were completed and it was advised this was a hardware issue. A formal incident report will be provided at the next Board for assurance. Concerns were raised on the unknown impacts on patients with X-rays being unavailable. Is there a mechanism for reminders to Clinicians of possible missing documents from this time? A Young noted within the incident report there will be a lesson learned, i.e., resilience and architecture of supplier and local business continuity. We need to ensure other options available. **Action – Carestream Incident Report - Radiology** No other comments were raised. **Assurance** was noted from the items discussed	**AY**
	3.2 GPIT Initial Agreement A presentation was delivered by M Richmond and noted this is a draft version of the initial agreement (IA). Apologies were noted this was not the final version but felt it appropriate to meet with all services to ensure comments and the needs of the services were met, upon consultation, a revised version will then be brought back to Board. M Richmond provided a brief background to the presentation noting: • GPIT will be a Once for Scotland • One GP cohort agreed • National Framework agreement – a single supplier Cegedim providing the Visions suite of products	

	• Scheduled release date of July 2023, we are currently working hard to achieve this • CyberLabs has been extended for another 2 years. For Order Comms we believe this is room for improvement, when we consider a suitable approach as part of the LIMS Replacement programme. M Richmond provided a brief overview of the benefits some are listed below: • Realisation of financial efficiencies from the removal of IT infrastructure. • Avoiding an increase in harmful events / near misses by ensuring continued provision of GP IT systems. • Financial efficiencies by the move to a centrally managed contract Although this is being led by a National Framework and we don't have a huge amount of choice. M Michie queried the financial funding arrangements and whether this was locally or nationally funded. M Richmond confirmed this is national funding through the GPIT system and provided a brief background to the financial arrangements. A Graham noted to Board this has been a project since 2018, which has been an extremely frustrating and drawn-out process with many different iterations. The benefits to NHS Fife are that other Boards are going through and will have completed a move to the new system so learning can be taken. S Mullan raised a query with the appointment booking system. M Richmond was unsure so will investigate and reply directly. No other comments were raised.	
	3.3 EPR M Richmond introduced item noting this has been brought to Board for awareness and to provide an update. They are pleased with the ongoing discussions that have been undertaken with SLT in Acute and the H&SCP and thankful for their input. The number of nominations and the engagement is reassuring. The ToR is currently being drafted and will be forwarded for review and comment. D McKenna queried if this is going to be paperlite, M Richmond confirmed this will be. There are some queries with the forms and how they meet the needs of the Practitioners that will use. No other comments were raised.	
4	**RISK MANAGEMENT**	
	4.1 Risk Management Report A Graham introduced paper and advised this report is for providing assurance to the Board. A brief update was provided to the paper noting the below: • There are a total of 37 risks which are actively being managed. • 7 Risks lower than the last report in October. • 11 high risks, 18 moderate, and 8 low. • 8 risks have seen improvement from a high rating to a now moderate or low risk. • 2 risks have now reached their target so these may be closed. • Risk 2192 was at a high, this was relating to ITIL 4, but this has since reduced.	

	A Graham provided a brief update to the categories and noted these are managed with the availability of systems, outages, and core infrastructure. Cyber Security is still high and always remains high with the constant threat of attack and to ensure that we are meeting the NISD responsibilities. A deep dive has been undertaken within the new corporate risk register and this has gone through governance. A brief update was provided to Risk 2192, work has been carried out with ITIL 4 and architecture and resilience. Dr McKenna thanked for the very detailed and information paper. Noting they believe the approach and presentation should be taken to other committees to make it easier to understand. A Graham noted there is currently an exercise within Information Services on Datix and also a possible dashboard format. No other comments were raised. **Assurance** has been taken from this report.	
5	**PERFORMANCE**	
	5.1 D&I Performance Summary A Young presented D&I Performance Summary from the last quarter, noting the below: • There has been considerable improvement within the 2003 and 2008 servers within the last quarter. • An upgrade to EMIS has brought the 2008 to 43 left. This is now leaving legacy applications. Work is continuing to reduce these as a priority. • We are now majority of Win 10. With only legacy systems, from suppliers that provide support and require to update to Win10. This is being managed on an exception list and working with supplier. • Work is currently being undertaken to improve our operating model. It is hoped this will help service-related requests and help with SLA's • SLA's remain steady. • Cyber Exposure Score, we are remaining under 30. This is an acceptable position and NHS Fife are routinely 3rd in Scotland across all Health Boards. M Michie queried the finance figure for November. It was noted this was an error – The performance report has been corrected to reflect the right amount. Dr McKenna thank all for their hard work and even during a challenging time, still producing good results. **Assurance** was taken from updated report.	
6	**Strategy & Programmes/Projects**	
	6.1 Programme & Projects Update M Richmond introduced this item and provided an update to some of the items within the project update. A brief update is noted below: • **eRostering** – We are now live in 8 services and work is ongoing to continue with others. There are a number of challenges with the National delivery of this project, but feedback has been provided. • **Near Me** – work continuing but more work to be achieved with the uptake of Community Hubs. • **EPR** – This project will commence with the appointment of a Programme Manager. To be reviewed.	

	• **Morse** – Nearly complete with migration 12 scheduled for Jan 23. Really pleased with the progress of Morse. • **Digital Pathology** – This has been delayed due to issues with delivery of scanners, but a delivery date has now been agreed and this will commence and hope to be back on track. • **NTC**. Ongoing, no issues have been reported. • **HEPMA** – ongoing conversations with Intersystems regarding the contract. Meeting scheduled to take forward. It is hoped there will be a positive position soon. Signed purchase order for IDD so work will commence on the plan for delivery. M Richmond highlighted a few smaller projects that have been good wins – Cytosponge and Chat Health are now live. M Richmond provided a brief overview on the current progress with LIMS. The status is currently red, this is due to the supplier, Citadel to supply a product. Conversations are ongoing with Scottish Government. We are in the process of negotiation an extension with current supplier. Further discussion was undertaken, and concerns were raised. M Richmond advised a meeting was held last week with Citadel and discussions on the deadline not being met. Replanning has been carried out with the National team and Citadel and a go live date of mid-June is the current baseline plan. Within this timeline there is still huge pressure and will need to work fast. Dr McKenna noted this has been presented to EDG which sought permission for the extension, and this now needs to be escalated to Clinical Governance Committee by a paper. **Action MR/AG to confirm LIMS update on CGC workplan.** C Somerville queried the ongoing support for eRostering. M Richmond advised conversations are ongoing with no outcome agreed yet. Dr Chalmers raised a query with discharge and delay and provided a brief background to their query. They feel that it would have been helpful for D&I to have been involved from the beginning. M Watts provided feedback and noted that funds were provided for D&I to support with additional funding provided. A brief discussion was held. M Michie queried the financials for the funding of LIMS extension till June. It was confirmed this has been provided by Scottish Government. **Action AG to forward the communication to M Michie of confirmation.** No other comments were noted. Paper is provided only for update to current projects.	**MR/AG** **AG**
	6.2 Delivery Plan M Richmond noted a few of the updates to the delivery plan were discussed in previous item, but a review is ongoing and will be presented at next Board.	
	6.3 SPRA Summary A Graham delivered a presentation to provide an update and to take assurance regarding the D&I SPRA response. A brief overview was provided, and the following updates were noted:	

	• Our current exposure to the annual Operating Costs for Clinical and Business Application are £730,000 • A revised Capital spend is going to be presented at the next FCIG • Within the SPRA this is broke down into 3 levels; National, Regional and Local and a few examples of these noted below ▪ National are: GPIT Re-provisioning, and eRostering ▪ Regional are: LIMS Utilisation, and Innovation ▪ Local: HEPMA, and EPR and Paperlite ▪ Continued commitment to cost improvement plan. C McKenna thanked A Graham for the presentation. No other comments were raised. **Assurance** was taken from updated report.	
7	**Finance**	
	S Marshall introduced their item and provided a breakdown of the finances for D&I in Month 8. (November 2022). • Variance Analysis – this is using the current months figures and taking the previous figures, forecast any movement in budget which is significant. Figures were provided. • D&I received £97,400 of reoccurring funds and these are broken down on page 2 of paper. • Overtime has been consistent over September, October and November with bank staff fluctuating due to the nature of demand. • Strategic fund of around 1.7million - £1.5 million allocated and £222,000 remaining. • Capital fund is around 4.7 million - £3.2 million allocated, £1.4 million spent and an overspend of £20,825. • Cost improvement plan (CIP) of recognised £244,113 A Graham noted the capital spend is linked to HEPMA and the supplier, but we are needing to be prompt with this. We are working closely with finance. M Michie raised a query regarding the Capital spend. S Marshall provided a brief update to query. It was decided this conversation to be taken offline for clarification. **Assurance** was taken from updated report.	
8	**Escalation to Clinical Governance Committee**	
	It was noted the LIMS should be escalated to Clinical Governance Committee by a paper.	
9	**Documents for Approval/Comment**	
	9.1 Draft Annual Workplan 23-24 It was noted this is draft and any comments to forward. **Action** – ALL to forward any comments on the D&I Workplan for 23-24	**ALL**
	9.2 Review of Draft ToR 23-24 Any comments to be forwarded for approval at next Board meeting. **Action** – ALL to forward any comments on the D&I ToR for 23-24	**ALL**
10	**AOCB** No other points were raised.	

	Dr McKenna thanked everyone for attending and for all continued hard work from D&I.	
10	**DATE OF NEXT MEETING** Wednesday 19th April 2023, 0900, via MS Teams	

FIFE DRUG & THERAPEUTICS COMMITTEE (Meeting on 8 February 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Fie Drug & Therapeutics Committee

NHS Fife

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 1.00PM ON WEDNESDAY 8 FEBRUARY 2022 AT 2.00PM VIA MICROSOFT TEAMS

Present: Mr Ben Hannan (Chair)
Dr Chris McKenna
Ms Shona Davidson
Dr Iain Gourley
Dr Claudia Grimmer
Ms Claire Fernie
Dr Helen Hellewell
Mr Fraser Notman
Ms Rose Robertson

In attendance: Ms Geraldine Smith (item 6.4)
Mrs Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the December meeting of the ADTC.

Apologies for absence were noted for Dr Caroline Bates, Dr Marie Boilson, Claire Dobson, Dr Ian Fairbairn, Dr David Griffith, Dr Sally McCormack, Dr John Morrice, Nicola Robertson, Andrea Smith, Mr Satheesh Yalamarthi, Doreen Young, Amanda Wong.

It was noted that due to lack of Acute medical representation the meeting was not quorate. It was agreed to progress with the meeting and circulate the minutes to members for agreement.

2 MINUTES OF PREVIOUS MEETING ON 7 DECEMBER 2022

The minutes of the meeting held on 7 December were accepted as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

Realistic Medicine Prescribing Group

It was noted that following discussions around embedding realistic prescribing within existing groups a review of the medicines governance structure & committees is underway and this will be brought to the ADTC in due course.

Roxadustat Clinical Guideline

It was noted that this will be taken forward as part of the Shared Care Group workplan. Mr Notman to liaise with Ryan Headspeath, Shared Care Pharmacist around the timeline for this. It will be brought back to the ADTC as part of overall shared care update in due course. **Action closed.**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Notman provided a verbal update from the East Region Formulary Committee (ERFC) on 1 February 2023 and highlighted key points from the meeting.

The two remaining adult ERF chapters (Malignant Disease and Immunosuppression) were approved at the meeting on 1 February. Work on developing the paediatric formulary has commenced.

A number of formulary applications were considered, the majority of which were for cancer medicines. An unlicensed/off-label application (FAF3) for abiraterone for high-risk hormone-sensitive non-metastatic prostate cancer was discussed and approved in line with National Cancer Medicines Advisory Group advice. Amendments to the ERF loperamide formulations due to the discontinuation of loperamide oral solution 1mg/5ml were also noted.

The ERFC also reviewed a request to approve a medicine outwith the SMC restriction (dapagliflozin for chronic kidney disease). The ERFC agreed to refer to the three ADTCs for a formal decision and communication will be issued in due course.

The ADTC noted the update from the East Region Formulary Committee and the good collaboration across the Region.

The ADTC also noted the approved minutes from the ERFC meeting on 30 November 2022. The minutes from the meeting on 1 February 2023 will be brought to the April ADTC for noting.

6.2 MSDTC

Mr Notman provided a verbal update on behalf of the MSDTC. A formal update report will be brought to the April ADTC meeting.

It was noted that John Brown, Head of Pharmacy - Clinical Services has taken over the role of Vice Chair from Andrea Smith. The Terms of Reference will be updated to reflect the change in membership.

The ADTC noted the update on behalf of the MSDTC and the approved minutes from the meeting on 26 October 2022. It was agreed that the Terms of Reference did not require to be brought to the ADTC for approval of the amendment to the MSDTC membership.

6.3 Antimicrobial Management Team

Mr Notman introduced the update report on behalf of the Antimicrobial Management Team (AMT).

The ADTC noted the current progress, achievements since the last update report and the proposed workplan for the next six months, including development of a strategic plan for the rolling review of all antibiotic guidance documents; introduction of dalbavancin to support and expand OPAT capacity; review of access to rarely-used antibiotics, allowing these to be delivered in a timely manner when there is an urgent clinical need; and continuing to ensure that NHS Fife complies with any updates to national guidance on antimicrobial stewardship and ERF infection guidelines.

The ADTC noted the resignation of the microbiology clinical lead which has led to the AMT lead taking on this role, diverting resources from AMT work over the last year. The ADTC requested further clarification on this point. Dr McKenna/Mr Hannan to take forward. **CMcK/ BH**

The ADTC discussed the issues highlighted around lack of dedicated Antimicrobial Pharmacist time and staffing resources within the Pharmacy Department. It was noted that the Antimicrobial Pharmacist has returned from a period of secondment and the issue around lack of dedicated time has resolved. Mr Hannan to look at staffing resources within the pharmacy department to identify if there are any issues for escalation. **BH**

The ADTC noted the publication of the Chief Nursing Officer's Infection Control Directive which refers to collaboration between the antimicrobial stewardship teams. The AMT to be requested to link in with nursing; Mr Hannan and Dr McKenna to discuss with Janette Owens, Director of Nursing. **BH/ CMcK**

The ADTC noted the update report on behalf of the Antimicrobial Management Group.

6.4 Medical Gases Committee

Ms Smith introduced the update report on behalf of the Medical Gases Committee and highlighted the current progress, achievements since the last update report and workplan for the next six months.

Good progress has been made with removal of the nitrous manifold in Queen Margaret Hospital and Phase 1 and 2 at the Victoria Hospital (in response to

the Scottish Government nitrous oxide implementation plan issued in May 2022).

Work to install a new manifold within the hospice to accommodate new W-sized cylinders, increasing oxygen capacity as well as reducing storage requirements has been completed.

Repair works have been completed following a significant incident that occurred whereby a car crashed near to the VIE tank at VHK.

In response to a National Patient Safety Alert issued around eliminating the risk of inadvertent connection to medical air via a flow meter, work to remove air flow meters from 9 wards and departments has been completed and nebulisers are now in place.

The ADTC noted the measures implemented locally in response to the national shortage of oxygen at the beginning of January 2023. It was noted that there is now an improved picture nationally.

The ADTC noted the comprehensive update report on behalf of the Medical Gases Committee and the important work ongoing. The ADTC also noted the minutes from the Medical Gases Committee meeting on 16 September 2022.

7 SBARs/Updates

7.1 Shared Care Group Terms of Reference

Mr Notman introduced the Terms of Reference for the Shared Care Group.

The Terms of Reference document clearly defines the role and remit and overarching principles of the Shared Care Group. The Group meets 4-6 monthly and membership includes a General Practitioner with dedicated interest in Shared Care (Chair), Associate Medical Director - H&SCP, Associate Medical Director - Emergency & Planned Care, Lead Pharmacist - Medicines Utilisation & Therapeutics, Senior Pharmacist - Shared Care and Senior Pharmacist - Primary Care. Specialist clinicians from relevant areas of practice are invited to attend meetings and/or contribute to the development and review of SCAs as appropriate.

The ADTC noted that the Shared Care Group is functioning well and the plan for prioritisation of work going forward is being finalised.

The ADTC noted a change required to Dr Helen Hellewell's title.

The ADTC noted that clarification was required on responsibility for informing patients when there is a change to a Shared Care Protocol. It was noted that it would be the responsibility of the prescriber to communicate with the patient on an individual basis however in the event of change being made which would affect large numbers of patients a co-ordinated approach would be taken to ensure that patients are not disadvantaged.

A discussion followed on the potential linkage between the Group and the prioritisation of local enhanced services relating to share care.

The ADTC approved the Terms of Reference for the Shared Care Group subject to amendment to Dr Hellewell's title. Responsibility for communication of changes to a Shared Care Protocol to be clarified.

7.2 Guidance for the Safe Delivery of Systemic Anti-Cancer Therapy (SACT) CEL 30 (2012) - Progress Update

Mr Hannan introduced the progress update SBAR and provided a verbal update on compliance with the Guidance for the Safe Delivery of Systemic Anti-Cancer Therapy (SACT) CEL 30 (2012).

The NHS Fife Board self-audit has been resumed and an action plan has been developed to take forward work any work required on areas of non-compliance. The action plan is monitored by the Acute Cancer Services Oversight Group which reports to the Cancer Governance and Strategy Group.

The ADTC noted the progress update report and was assured that robust monitoring mechanisms are in place. It was agreed that an update should be brought to the ADTC on an annual basis. Updates on the actions will be taken the Acute Cancer Service Delivery Group on a monthly basis.

8 Risk Register

Mr Notman took the ADTC through the risks scheduled for review and highlighted the proposed template for presenting risks to the Committee.

Risk 522 - Prescribing Budget
It was noted that this risk originated in 2006 and it had previously been agreed at ADTC that refinement was required. There was a discussion around the risk owner and noted that currently Dr McKenna is recorded as the risk owner. Consideration to be given to removing this risk in its entirety and creating a new operational risk with Mr Hannan as risk owner. More detail around the mitigations, risk levels and tolerance and how the risk aligns to the overall corporate level risk around financial sustainability is required. **BH/FN**

Risk 1347 - Out of Date Shared Care Protocols
The ADTC noted the update on progress with regard to the risk around out of date Shared Care Protocols. It was noted that several meetings of the Shared Care Group have taken place and the Terms of Reference has been agreed. The Policy & Procedures document is awaiting finalisation. Discussions regarding a combined methotrexate Shared Care Protocol for Rheumatology/ Dermatology/ Gastroenterology are ongoing. Shared Care Protocols identified for progression include valproate and testosterone for women.

Risk 1621 - Medicines Shortages
It was agreed that there are two elements to risk 1621, the patient care impact and the impact of the increase in the cost of medicines.

It was noted that there are a number of medicines shortages that could potentially impact on patient care and medicines shortages remain a challenge for patients, GP practices and Community Pharmacies.

A discussion followed and the ADTC noted that further awareness/ assurance was required with regard to the mechanisms in place for managing medicines shortages through independent contractors. A piece of work to be taken forward to establish what mechanisms are in place currently and what additional support could be provided locally. Mr Hannan to discuss with Hazel Close, Head of Pharmacy - Population Health and Wellbeing to request that this be taken forward through the workplan of the Pharmacy Champions. **BH**

Following discussion it was agreed that the medicines shortages risk should remain. The financial aspects of medicines shortages to be removed and incorporated into the refined financial risk.

The ADTC was supportive of the proposed template for detailing risks scheduled for review, subject to refinement to include the addition of current and target risks, details of risk owner and date that the risk originated. Mr Hannan/Mr Notman to take forward. **BH/FN**

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

None for discussion/noting.

10 EFFECTIVE PRESCRIBING

10.1 National Cancer Medicines Advisory Group 102 - Abiraterone
10.2 National Cancer Medicines Advisory Group 104 - Carfilzomib
10.3 National Cancer Medicines Advisory Group 105 - Trastuzumab
10.4 National Cancer Medicines Advisory Group Quarterly Update

Mr Notman highlighted the National Cancer Medicines Advice documents NCMAG 102, NCMAG104, NMCAG105 and quarterly update.

It was noted that in the absence of a national process for taking forward NCMAG advice, unlicensed/off-label (FAF3) applications should be completed and reviewed through the ERFC in order to maintain the governance structure for the use of these medicines.

It was also noted that under Direction of Scottish Government, Healthcare Improvement Scotland are considering the scope of CEL17 - Introduction and Availability of Newly Licensed Medicines in the NHS in Scotland.

The ADTC noted the National Cancer Medicines Advice documents and the process in place for review of these through the ERFC.

11 HEPMA Update

Mr Hannan provided a verbal update on the implementation of HEPMA. It was noted that work is ongoing with regard to implementation of medicines reconciliation and replacement for the existing electronic immediate discharge document. A detailed update to be brought to the ADTC in due course.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

14 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation to the Clinical Governance Committee. **CMcK**

15 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 13 December 2022**. For information.

b **Minutes of Heart Disease MCN Prescribing Sub-Group 1 December 2022.** For information.

c **Minutes of Respiratory MCN Prescribing Sub-Group** - *not available*.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 26 April 2023 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 12 April.

FIFE IJB QUALITY & COMMUNITIES COMMITTEE **(Meeting on 8 November 2022)**
No issues were raised for escalation to the Clinical Governance Committee.

Fife IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
TUESDAY 08 NOVEMBER 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 Martin Black, NHS Board Member (MB) Ian Dall, Service User Rep (Chair of the PEN) (ID) Morna Fleming, Carer's Representative (MF) Paul Dundas, Independent Sector Lead (PD)
Attending:	Nicky Connor, Director of HSCP (NC) Dr Helen Hellewell, Associate Medical Director (HH) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Lynne Garvey, Head of Community Care Services (LG) Rona Laskowski, Head of Complex and Critical Care Services (RLas) Audrey Valente, Chief Finance Officer (AV) Roy Lawrence, Principal Lead for Organisational Development & Culture (RL) Fiona McKay, Head of Strategic Planning, Performance & Commissioning (FMcK) Amanda Wong, Director of Allied Health Professionals (AW) Fiona Forrest, Deputy Director of Pharmacy (FF) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Kenny Murphy, Third Sector Representative (KM) Simon Fevre, Staff Side Representative (SF) Elizabeth Butters, Fife Alcohol and Drugs Partnership Service Manager (EB) Hazel Close, Head of Pharmacy - Population Health and Wellbeing (HC)
In Attendance:	Jennifer Cushnie, PA to Associate Medical Director (Minutes)
Apologies for Absence:	Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Lynn Barker, Director of Nursing Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed all to the meeting, she wished to thank staff for their ongoing efforts in a particularly challenging period for Health & Social Care. She advised, timings for presenting reports would be strict due to a very heavy agenda. The ADP Lived Experiences Development Session will commence at 12noon, straight after the finish of the Committee meeting.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 09 SEPTEMBER 2022** The previous minutes from the C&CGC meeting on 09 September 2022 were approved as an accurate record of the meeting.	
5	**GOVERNANCE**	
	5.1 Revised Quality & Communities Committee Terms of Reference (re Quorum) It was asked if there were any queries regarding the amendment to the Terms of Reference relating to Quorum. There were no questions or comments, therefore, the Committee approved the revised Terms of Reference.	
	5.2 Primary Care Implementation Plan – MoU2 Progress Update LC introduced the report for discussion and assurance around ongoing implementation of the PC Improvement Plan. LC outlined the background to the Plan and the reasons behind it, the primary areas of focus and told of the revised MoU which was necessary due to the COVID-19 pandemic. LC stated the Vaccination Transformation Programme (VTP) fully transferred to NHS Board responsibility in March 2022. She gave updates around Pharmacotherapy and CTAC, both of which are unlikely to be fully transferred by the original aim of April 2023. A summary of the 6 Workstreams and their remit, progress achieved to date and the difficulties being addressed was given. LC highlighted, in line with MoU2, the risk of transitionary payments possibly being required if Boards are not successful in reaching what has been directed Nationally. HH commented the implementation of the Plan is being done in a way to add quality and safety for patients. She added, the multi-	

	disciplinary teams are highly effective professionals and there is robust clinical governance around the whole process. Questions were invited from the Committee. KM thanked LC for the Paper and was supportive, however, he queried the loss of £5M and asked if Scottish Government had given warning underspend would be clawed back. LC explained, 'slippage' within the budged occurred due to the way in which the funding streams were awarded and the ongoing workforce challenges. She advised, it was not anticipated any underspend would be offset against future funding and a lot of work took place locally looking at how it would support ongoing implementation of the PCIP. LC confirmed a proactive approach is being taken to minimise any risk of underspend going forward. Cllr Downie was interested to hear the answer to KM's query and looked for reassurance, pressure to spend funds will not lead to short term thinking, but always long-term implementation being the aim. He was keen to hear if there have been any problems implementing the Plan within 2C Practices. He was very supportive of the 'The Well' community-led programme, however, was disappointed at the lack of attendance and queried if this can be encouraged. HH gave assurance the implementation of the PCIP has been thoroughly planned with no short-term thinking. She told of Plans in place to combat workforce challenges within any MDT group. LC seconded HH and gave assurance 2C Practices have not been impacted but has raised awareness of the importance and value of MDT within 2C Practices.	
	5.3 HSCP Winter Planning LG apologised for the late circulation of the paper. She explained the reason for it being brought to the Committee, was to give an overview of actions being taken by the Partnership. The report intentionally does not highlight outcome measures, rather, it gives assurance of what HSCP will do in preparation for winter. This will be followed up at subsequent meetings with a range of outcome measures. LG talked through the four sections within the paper, the Annual Delivery Plan, Local Priorities, Workforce and Recovery and Protection of Planned Care which gave an overview and looked to give assurance of the significant steps and measures being taken to address the challenges ahead this winter. M Black thanked LG for the paper and queried if there is a timescale for assessment being carried out at home. LG advised, to carry out assessment at home, it must be agreed with the patient and their family whilst the patient is in hospital. Assessment will take place after 2-3 days, up to one week. If there is delay due to pressures, it will be explained to the patient. This will be highlighted to the patient whilst in hospital. A very useful leaftlet explaining the service is also being developed which will be given to all patients. I Dall referred to the problem of staff recruitment and felt it was being underplayed, particularly in NE Fife. He suggested a deeper dive be	

	undertaken. LG agreed it is a big issue and welcomed any suggestions and told of various approaches which are being used. STV campaign was referred to as well as 'winter heroes'. She told of 14 interviews being held this week, which was a positive improvement. Cllr Kennedy commented the report was a very positive document and referred to the difficulties around recruitment, acute beds and the challenges of moving through the system. She highlighted the huge importance of communication with patients, outlining clear timelines. She acknowledged the huge demands being faced. LG spoke of recruitment challenges and promotional work taking place along with various initiatives being engaged. She agreed the communication component is vital and described how patients will receive a discharge plan with 'what matters to you', on admission to VHK. The plan will stay with the patient as they move through VHK and on towards community hospital or home. LG referred to the Discharge Without Delay video clip which is being developed and will be shared with patients before entering acute hospital, showing what discharge will look like and the services available. She stressed the importance of managing expectations. Cllr Kennedy queried how the communication will be delivered, to enable councillors to signpost. Promotion of links to information sites was discussed and the use of Social Media as a tool. LG suggested promotion can also come through Sway. NC felt there is a culture change to be supported as robust communication becomes the normal. P Dundas welcomed the paper, he acknowledged it is very difficult to attract, recruit and retain staff, particularly locally and was pleased to hear of 14 candidates for interview. He felt there is no local or national oversight as the social care data is 18-24 months out of date. He stated more current and relevant data is being sought and explained the work taking place. SB thanked LG for the Winter Plan and the Committee took assurance from it.	
	5.4 Pharmaceutical Care Services Report 2021/22 FF introduced Hazel Close, Head of Pharmacy - Population Health and Wellbeing to present the report. HC advised the report is brought to Committee for Assurance and is presented annually. During the pandemic, however, permission was granted by the IJB to suspend provision of the report during that time. HC stated Pharmacy, in line with Pharmacy Regulations, are legally obliged to submit the Report, which sits within the complexity of both Primary Care and Independent Contractors. She advised, in terms of Community Pharmacy, provision is delegated to IJB, however, the Regulations and Pharmacy Regulations are enacted by the Health Board. The Paper reports on Pharmaceutical Services provided by Community Pharmacy across NHS Fife. It has been approved	

	through the Public Health and Wellbeing Committee 07.11.22 and will go to IJB on 25.11.22. HC told of the public engagement process involved where the report goes out to a number of panels, including the Patient Focused Public Involvement Panel, for a period of 8 week, feedback is then incorporated into the report. The report describes all the Services provided by Community Pharmacy and the positive impact they have on customer care. HC highlighted several points from the report and the Committee were invited to ask questions. Cllr Liewald commented the report is outstanding and asked if the breakdown of services, those which are vital to men/women on the street, could be distributed along with the discharge winter readiness leaflet. HC thanked Cllr Liewald for her comments and will link with FF. MF referred to Emergency Contraception and Bridging Contraception figures and asked if Fife's numbers are in line with the rest of Scotland. HC assured the numbers are in line with other areas of Scotland and advised Community Pharmacy are almost the sole providers of these types of contraception.	**HC / FF**
	5.5 Professional Assurance Framework Report (NMAHP) HH introduced the report on behalf of LB. She advised, it is presented for Assurance and is very comprehensive in the way it is set out. She stated there has been very little substantive changes, only to take into account new strategies and to update accordingly. The nursing process of how the Board gets assurance has not changed. There were no questions or comments.	
	5.6 Quality & Communities Strategic Risk Register AV introduced the report which states the Risks relating to the Quality & Communities Committee. The Risks were reviewed in October 2022. KM asked to clarify if the Report is a subset of the Full Risk Register and does each Committee receive a subset of Risks, therefore all Risks are owned by at least one Committee. AV confirmed this to be correct.	
	5.7 Fife Specialist Palliative Care Services (FSPCS) – Service Model SB stated the report is strictly confidential and not for re-sharing. LG introduced Joanna Bowden, Palliative Care Consultant.and Karen Wright, Clinical Service Manager Palliative Care who have been leading on the significant redesign of the Service. The report is brought for confidential discussion. FMcK reiterated the Paper is a	

	discussion paper and clear Participation and Engagement work is underway. Views from the Committee are invited which will help form how the Paper is taken forward. A slide presentation was shared on screen. NC advised the report will come back to Q&C in January on route to the IJB, where it will be for discussion, decision and support. Currently, it is seeking support and input. KM commented on the Service Users Voice and Engagement / Consultation was at the end of the report and he felt it would have been better up front. From the presentation, more so than the report, KM felt, the Service seems to be Service User centered. He also felt more meaningful involvement from Service Users, rather than just feedback, which he explained, would be beneficial. Cllr Downie felt, as well as sharing positive feedback, concerns and negative feedback should also be included in the Appendix to give balance. He referred Scottish Government's intention to review their Palliative Care Strategy and asked if Fife will be feeding into/ contributing, however, he was aware delays are being experienced. JB welcomed all comments and helpful suggestions and agreed placing communities, patients and families at the forefront is fundamental. She explained the research study capturing the reality of care and experience across fife and the plans to capture feedback from all. She told of close working with Scottish Government and the importance of sharing the progress and examples of innovation within Fife should be shared Nationally. LG re-emphasised, over the past two years there has only been two complaints, which she described. However, there has been a large number of compliments and positive comments. NC advised for assurance, she has been invited to join the Palliative Stategic Development Committee at National level, the first meeting has taken place and she assured Fife is in alignment with the National direction, if not ahead.	
	5.8 Workforce Strategy and Action Plan 2022-25 RLaw presented the Report for Decision. He advised positive feedback had been received from Scottish Government who support a recommendation for Fife IJB to approve the Strategy. It is intended for the HSCP Workforce Strategy and Plan be published on the Partnership website on 30.11.22. RL outlined the engagement and consultation which has taken place prior to submission to Scottish Government. He explained how the Strategy and Plan reference workforce priorities, organisational strategies and workforce activities across the Partnership. Feedback was extremely positive and RLaw gave examples of the comments received. The Committee was content to recommend to the IJB for approval.	
	5.9 Strategic Plan 2022 – 2025 (Version 0.1)	

	FMcK introduced the Strategic Plan which has been developed by the Strategic Planning Working Group, Heads of Service and Senior Managers across HSCP. The Plan is an overarching document which all other work will link back to over the next 3 years. FMcK advised a Requirement came from Scottish Government outlining what should be included and will ensure the Requirement is strictly adhered to. The Plan is aligned to new priorities which are Local, Sustainable, Wellbeing, Income and Integration. From these, each of the Strategies will link directly, outlining the plans which relate to the priorities. The document is still out for consultation and FMcK encouraged the Committee to complete and return the questionnaire. The Plan is brought to Committee to give Assurance all work has progressed as planned. The full report will be brought to IJB at end November / early December 2022. Cllr Liewald asked for a link to the Easy-Read. FMcK will forward to Cllr Liewald.	**FMcK**
	5.10 Care Inspectorate Grades for Social Services FMcK introduced the Report which is an annual inspection report around the care and support services which HSCP provide or commission. She explained the grades and how they are used to ensure services continue to meet the standards and needs of people using the service. Where a low grade of 2 has been awarded, there will be a comprehensive plan to improve with involvement from the Partnership. If necessary, the Partnership will stop placing in a Care Home until work has taken place to improve where necessary. FMcK confirmed the Partnership are always working with providers to improve their position and grades. ID commented on a Care Home which is regularly awarded a 2 grade and asked if we will stop using them. FMcK stated the Care Home ID referred to has gone through periods of being at 2 and then improving, however, people want to go there. She felt strongly people should be allowed to make choices and advised the Partnership are continually working with the Home to improve where required. The Committee took assurance from the report.	
	5.11 Health and Social Care Day Services for Older People FMcK presented the report to update the Committee of the Day Care Services provided for older people in Fife. She advised pre-pandemic, a programme of redesign had begun, however, this work was suspended with the outbreak of Covid. FMcK told of a programme which has commenced working with Third Sector Organisations to support them to delivery Day Care Services on behalf of HSCP. The programme will use Partnership buildings to provide the Services. FMcK told of a pilot taking place in Napier	

	House, Glenrothes with Later Life Choices. The feedback has been exceptional from both Service Users and from the people providing the services. She also described work being carried out in the NE Fife area and RVS supporting day care services in the Tayport area. This is being redesigned through consultation with the people who previously used day care services. Work with hubs for people with dementia was also outlined.	
	5.12 Fife Alcohol and Drug Partnership Annual Report 2021/22 FMcK presented the Report which is submitted to the Government on an annual basis. The work taken forward around the MAT Standards is highlighted within the report. Scottish Government requested HSCP to self-assess which was followed by assessment by Scottish Government around the areas of practice. FMcK was happy to report 'amber' status was achieved in all standards and work is underway to achieve 'green' status by early 2023. During the Development Session following the Committee Meeting, people from the Lived Experience Group are invited to give their views on the Services provided.	
6	**ITEMS FOR ESCALATION** No items for escalation.	
7	**AOCB** No further items raised.	
8	**DATE OF NEXT MEETING –** Wednesday 18th January 2023, 1000hrs MS Teams	

Fife IJB QUALITY & COMMUNITIES COMMITTEE MEETING

(Meeting on 18 January 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Fife IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
TUESDAY 18 JANUARY 2023, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Graeme Downie Councillor Lynn Mowatt Councillor Sam Steele Ian Dall, Service User Rep, Chair of the PEN (ID) Morna Fleming, Carer's Representative (MF) Paul Dundas, Independent Sector Lead (PD)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Lynne Garvey, Head of Community Care Services (LG) Rona Laskowski, Head of Complex and Critical Care Services (RLas) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Simon Fevre, Staff Side Representative (SF) Heather Bett, Interim Senior Manager Children Services, Sexual Health & BBV and Rheumatology (HB)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Cllr Margaret Kennedy Dr Chris McKenna, Medical Director Ben Hannan, Director of Pharmacy and Medicines Lynn Barker, Director of Nursing Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO) Nicky Connor, Director of HSCP Roy Lawrence, Principal Lead for Organisational Development & Culture Fiona McKay, Head of Strategic Planning, Performance & Commissioning

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** The Chair welcomed all to the meeting, she wished to thank staff for their ongoing efforts in a particularly challenging period for Health & Social	

	Care. She apologised for the late issue of the Quality & Communities Committee meeting papers and the reduced agenda, which is due to the current pressures on Services.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 09 SEPTEMBER 2022** The previous minutes from the C&CGC meeting on 08 November 2022 were approved as an accurate record of the meeting.	
5	**GOVERNANCE**	
	5.1 Mental Health Strategy Progress Report RL introduced the report which is an update on the status of implementation of the existing Mental Health Strategy and preparedness for the intended Fife Mental Health Strategy. The report gives an update on business which has been finalised over the past 6 months and examples of where Fife are in other areas of practice. RL referred to good news stories reflected in the report. She advised Action 15 monies have been confirmed to be awarded on a recurring basis and described the range of programmes this supports. She advised, although there has been significant investment in mental health, new requirements are requested by Scottish Government. RL referred to the range of renewal and recovery initiatives instructed by Scottish Government, each with their own funding stream. She touched on the difficulties around lack of flexibility and the challenges meeting local needs in Fife. CAMHS and Psychological Therapies have been heavily invested in. RL spoke of the backlog and gave details of the current situation, giving assurance work is progressing. Activity described included Mental Health and Wellbeing Hubs at Primary Care level. RL told of the work taking place within the Hubs at each of the 7 localities. RL explained the changes within Redesign/ Replacement of the MH Inpatient Estate. This is a long-term programme involving replacing redesign and/or replacing psychiatric hospital sites with fit-for-future hospital /s. It is anticipated this will come through governance to both IJB and NHS Fife Board over the next couple of month, prior to submission to SG. RL outlined other areas of work being progressed within the Service, including Community MH Estate, development of pathways of care and the new national strategy for Scotland.	

	The challenges of significant workforce gaps and the initiatives being utilised to help improve recruitment were outlined and RL advised work is underway to explore models from 3rd sector agencies, providing reach/ outreach models to enhance the patient experience and build successful discharge pathways. Questions/comments were invited. MF thanked RL for her detailed presentation and raised several points including staff recruitment challenges, training and funding. RL covered all queries raised. Cllr Liewald referred to the strategy monies which have been made available and queried the degree of flexibility which can be employed at Fife level. RL confirmed the areas of priority for any such monies will be first point of contact at Locality Hubs and Out of Hours care. She detailed some of this work. Cllr Downie queried when the MH services bench marking for OOH was recorded. RL confirmed the data was reported Nationally in early 2022, data coming from late 2021. RL offered to bring back a report specifically looking at benchmarking. Cllr Downie indicated he would appreciate more specific data coming back to Committee. ID asked to see more in Post Diagnostic Support and OOH support for dementia Carers. RL outlined the current status of Post Diagnostic Support services and advised she will take away the point regarding OOH support for Carers and give an update within the next MH Strategy Update Report. SB was interested to note prescribing rates in depression are similar across all areas, although deprivation has been proven to have a detrimental effect on mental health. HH stated prescribing is not always the best indicator of mental ill-health within an area due to the complexity of the illness and the method of help provided to an individual. She gave assurance this is being considered within the Primary Care Strategy. Other areas discussed were dependence on locum consultants, recruitment and workforce challenges.	
	5.2 Suicide Prevention Strategy LC requested this report be deferred to the next Committee meeting. This was agreed.	
	5.2 Violence Against Women Annual Report 2021/22 The report is brought to the Quality & Communities Committee to inform and assure of the work being undertaken within NHS Fife, Fife Health and Social Care Partnership and Fife Violence again Women Partnership (FVAWP) to address violence against women and girls. She advised the report contains 3 detailed annual report from April 21 – March ’22, underpinning the Safe Scotland Strategy which is designed to prevent / eradicate violence against women and girls.	

	LC introduced Heather Bett, Senior Manager Children Services, Sexual Health & BBV and Rheumatology. HB began by commending the work undertaken by small teams working extremely hard to provide quality interventions and services to women and girls across Fife. She gave background to the 3 reports - Fife Violence Against Women Annual Report - a multi-agency partnership involving HSCP, Police, Education and Social Work and described the stands of work being taken forward. Marac Annual Report - multi-agency risk assessment conferencing, an approach used to support those at the highest risk of violence. Fife HSCP Gender based Violence Service annual report - sitting within HSCP offering a range of services, including a gender based violence care pathway, the forensic care pathway and the children and young people's care pathway which HB described. Questions were invited. SB asked HB to convey thanks to the teams for the work they are carrying out in very difficult circumstances. She commented on several reports in the media recently regarding violence and attitudes towards women. Cllr Liewald referred to the "What Were You Wearing" exhibition which she and other elected members attended and commended the good work which is taking place and she felt changing the attitudes of young males. SF queried if there are opportunities to increase the workforce and if there is support in place for the staff carrying out this work, which at times can be very difficult. HB advised, staffing is fully established within the HSCP team, however, work is spread over wider teams which she described. She added, training and development is an area of work to be focussed on, although support is provided through the Sexual Assault Centre. Cllr Steele referred to the Caledonian Programme and the men which did not complete the course during the pandemic. She queried if there was a follow up to this. HB will check with Social Work colleagues and contact Cllr Steele outwith the meeting.	**H Bett**
6	**ITEMS FOR ESCALATION** No items for escalation.	
7	**AOCB** No further business raised.	
8	**DATE OF NEXT MEETING –** Friday 10th March 2023, 1000hrs MS Teams	

HEALTH & SAFETY SUB-COMMITTEE

(Meeting on 20 January 2023)

No issues were raised for escalation to the Clinical Governance Committee.

Health & Safety Sub-Committee

Minute of the H&S Sub-Committee Meeting
Friday 20 January 2023 at 12.30 pm on Teams

Present
Neil McCormick (Chair), Director of Property & Asset Management (NMcC)
Rona Laskowski, Head of Complex Critical Care Services, Fife HSCP (RL) (1.50 pm)
Kevin Reith, Deputy Director of Workforce (KR) for David Miller

In Attendance
Paul Bishop, Head of Estates (PB)
Billy Nixon, H&S Manager (BN)
Ann-Marie Marshall, Acting Senior H&S Advisor (A-MM)

Andrea Barker (AB) Minute

The order of the minute may not reflect that of the discussion

No.		Action
1.	**Welcome & Apologies** NMcC welcomed those present to the meeting. Apologies were noted from Dr Chris McKenna and David Miller (Kevin Reith). NMcC commented on his concern over the lack of Staff side representation.	
2.	**Minute/Matters Arising**: The Minute of 02.09.22 (amended*) was approved as an accurate record. Minor amendment*: Item 5.2 - H&S Incident Report (Apr - Aug 22) Violence & Aggression • KR added that from an HR workforce point of view, V&A remains a continual topic of discussion at national level around the ~~statute of~~ **statutory and** mandatory standards across the whole of the sector.	
3.	**Covid-19 Update**: 3.1 Covid-19 Risk Assessment BN advised that Julia Cook (JC), IPCT had been in contact in relation to the Covid-19 Risk Assessment INPCM appendix 20 - removal of the reference to the 2 m social distancing rule. He went on to explain that she feels that this now has implications in relation to the NHS Fife Local Risk Assessment including RP requirements around poor ventilation and over-crowding. JC is keen to keep protections in place. On-going.	

	3.2 Relaxation of Masks NMcC - Several changes have been made around the relaxation of mask wearing in dining rooms and non-clinical areas of the hospital; however mask wearing remains in place in clinical areas. Many of the Covid-19 changes were to ensure that staff had proper rest breaks and down time versus the continuing risks of exposure to Covid-19. Covid-19 numbers continue to fluctuate which has been causing various problems throughout NHS Fife, with ward closures in the Community and hospital settings due to localised Covid-19 breakouts.	
4.	**Governance Arrangements**: 4.1 Terms of Reference (ToR) A copy of the 'draft' ToR for the H&S Sub-Committee was distributed to members of the group. (a) The ToR has been updated to reflect the fact the David Miller is now a lead executive on the Group from a Workforce point of view replacing Linda Douglas who has retired. **The update was agreed by the group** (b) Consideration was given to inviting Janette Keenan, Director of Nursing to join the group in terms of manual handling, violence & aggression and IPCT. **The proposal was supported by the group** and will allow for more resilience for members (c) It was suggested that 'nominated representatives or their deputies' be added to the ToR to ensure continuity around attendance at each meeting. **The suggestion was agreed by the group** **Action** • The 'draft' ToR will be updated to include the changes above. • The ToR will be presented at the next meeting on 10 March 2023 for final approval. 4.2 Annual Statement of Assurance NMcC - The Annual Statement of Assurance will be presented to the group for approval at the next meeting on 10 March 2023. 4.3 Annual Work Plan 2023-24 The H&S Sub-Committee Annual Work Plan 2023-24 was distributed to members of the group. NMcC added that this is a very helpful and robust rolling document which	**Andrea** **Andrea**

	can be updated meeting by meeting, where required. The Annual Work Plan 2023-24 will be published at each H&S Sub-Committee meeting and any changes will be reflected accordingly. **The group approved the H&S Sub-Committee Annual Work Plan 2023-24**	
5.	**Operational Updates** 5.1 H&S Sub-Committee Incidents Report (Sept-Nov 2022) A copy of the H&S Sub-Committee Incidents Report (Sept-Nov 2022) was distributed to members of the group. BN presented his first H&S Sub-Committee Incidents Report for the period September to November 2022 to the group in his role as H&S Manager. (a) Sharps Group - BN has spoken with Claire Dobson, Director of Acute Services with the aim of Sharps being a standing agenda item on the Acute Health & Safety Committee which is in the process of being set-up. The Sharps Group will then eventually disband. (b) Sharps Datix Reporting - There has been several Datix incidents recorded recently, however, these have not been supported by an accompanying SBAR. This was a requirement highlighted by the HSE during a past visit. BN will chase - on-going. (c) Slips, Trips & Falls - data shows an additional 9 incidents based against last year's figure. (d) Violence & Aggression A breakdown of V&A incidents recorded to date: • 35 incidents in Acute • 240 incidents in HSCP; with Mayfield having the greatest number Violence & Aggression Advisor Bill Coyne will start with NHS Fife's Health & Safety team as Violence & Aggression Advisor on 23 January 2023. (e) Manual Handling BN extended a thank you to A-MM and Brian Ritchie, Assistant H&S Advisor for their assistance with inductions and staff training due to the sudden retirement of the previous Manual Handling Advisor post holder. Since mid-June 2022, details of staff who have requested training and have been unsuccessful in securing a slot on a training schedule have been recorded. The list is cross-referenced with the Annual Manual Handling Database. The training is then categorised into 2 sections; those staff who require an induction and staff who require an update. Interviews for the Manual Handling Trainer vacancy will be held in February 2023.	

The Manual Handling Co-ordinator post is now on the vacancy list for re-deployment purposes.

(f) Patient Self-harm

To date, there were 44 self-harm incidents reported; 4 more than this time last year, of which 2 were completed suicides:

- 21 no harm
- 18 minor
- 3 moderate
- 1 major
- 1 extreme

(g) RIDDOR

For reporting purposes BN advised that RIDDOR has been split into:

- RIDDOR Reports
- RIDDOR (those not yet known)

BN provided an overview of RIDDOR related incidents to the group.

(h) RIDDOR (those not yet know)

NMcC - the report highlights 3 individual CSSD issues, however, we have no CSSD facilities in Fife.

Action

BN will investigate NMcC's query and report his findings back to the group. **BN**

BN welcomed comments from group members on the Incident Report

KR - Incident Report - The format is clear overall. Although narrative was provided, it would be interesting to view trend lines year-on-year across all measures, if possible.

KR - RIDDOR (not yet known) Incidents Table - it would have been useful to see an incident date on the table with a view to understanding whether this is something you are challenged with in terms of responses in good time order.

RL - Under the Self-harm section of the Incident Report, 2 completed suicides happened at home which raises the question why have these incidents been recorded under Health & Safety given we have no control or responsibility over this environment?

For patients who have been with Community Services, HSCP for a period of 12 months or more, completed suicides must be reported through the Mental Welfare Commission. The HSCP has responsibility for the clinical treatment of patients in their own homes; however, do we have responsibility under health and safety?

Action

	Self harm incident reporting - discussion to follow out with the meeting with BN and RL on the reporting of relevant statistical information moving forward. NMcC – Happy that the Incident Report has been produced in an easy to read format and includes data for the whole of Fife. Conversations around the scrutiny of data during meetings are exactly what we are looking for in terms of what information is contained in the Incident Report, with a view to its overall development. Looking forward, perhaps when we have a full year of data, we could widen discussions with the Area Partnership Forum, Clinical Governance Committee and Staff Governance Committee. BN would be happy to receive further comments and/or feedback out with the meeting. Thanks were extended to BN and his team. 5.2 Staff Governance Standards - Improved & Safe Working Environment SBAR A copy of the Staff Governance Standards – Improved & Safe Working Environment SBAR was distributed to members of the group. NMcC - the SBAR was presented to the Staff Governance Committee where it was well received. The SBAR is documented today at the H&S Sub-Committee for information purposes. There is concern from Unions around stress in the workplace. Looking at best practice and the H&S Executive's best practice, a talking toolkit is available with a number of questions which highlight areas for discussions we should be having with our staff. Pilot Scheme - the toolkit will be piloted in several HSCP areas and Wendy McConville has volunteered 2 areas of which she has responsibility namely; a ward area and a community setting. Information gathered from the Pilot Scheme will be incorporated into a Risk Assessment which will show exactly what is being implemented, particularly around improvements for staff. The toolkit should prove to be a positive communications tool with consideration given to learning from the information gathered throughout the wider organisation. We ought to be aware, however, that some of the feedback may be quite challenging and consideration should be given as to how we deal with this moving forward. This practice will effectively join up areas of the HSCP into the Fife wide Health & Safety Sub-Committee. RL - it is likely that this is going to have a link with the APF and the LPF in the partnership with similar meetings in Fife Council. Information gathered will add to the evidence on the impact of high levels of vacancies, the	**BN/RL**

impact of not enough workforce and stress factors due to this.

KR - the toolkit was really well received at the Staff Governance Committee. We are being really proactive around this issue by utilising appropriate toolkits and information and incorporating best practice terms. Staff Side are happy with this approach. Overall we will gain some insight from the initial Pilot Scheme and then how we roll this out further from there.

NMcC - The paper will also be presented at APF next week.

5.3 Manual Handling

(a) H&S Manual Handling Training Audit of 13 January 2023

A copy of the H&S Manual Handling Training Audit was circulated to members of the group for information.

A-MM - Manual Handling training and compliance for staff is relatively low at the moment, however, there is a lot of work being carried out behind the scenes to move this forward.

The H&S Manual Handling Training Audit was actioned to see exactly what training measures have been carried out and what training measures have been put in place over the past 15 months.

The audit tool used was one from the Scottish Manual Handling Passport Scheme and is being used by the service to ascertain what training is in place and what training plans are in place for staff within the organisation.

Uptake and compliance is poor in several areas due to staffing issues ie annual leave, sickness/absence.

The Audit, however, has shown that we are in a good position overall: with our compliance figure sitting at 80.35%.

Self-assessment Checklists

A-MM reported that the paperwork is complete to meet the current gap:

- Self-assessment Checklist for Patient Handlers
- Self-assessment Checklist for Non-patient Handlers

The above checklists will be distributed at ward/unit level. These checklists will be completed by each individual member of staff and, once returned, the scoring will determine what training is required and what we have to put in place to meet individual requirements.

PB - extended thanks to the Manual Handling team who were involved in the improvements made.

KR - Overall, the Statutory and Manual Training compliance, of which Manual Handling plays a part, was causing a bit of concern at Board level as training figures were showing a bit of decline.

KR - In preparation for the next report which is being presented at the March 2023 Staff Governance Committee and for assurance purposes, it would be beneficial to add some background to this in order to reflect the

	positive work being carried out behind the scenes by the Manual Handling Team. **Action** KR to contact A-MM out with the meeting to discuss the report content. (b) Manual Handling Training Plan 2023 A copy of the Manual Handling Training Plan 2023 was circulated to the members of the group for information. Course data from 2022 was used to set up a projected 2023 plan by A-MM. The Plan is based around the condition that 2 new Manual Handling Trainers will be in post. Interviews will take place on 2 February 2023. Brian Ritchie, Assistant H&S Advisor continues with one Induction Training Session per week for new members of staff. A-MM continues to carry out Hospital and Community Update Sessions etc. Hopefully, from March 2023, additional Induction Training Sessions will be available to those members of staff who still require induction. Predominantly, this relates to staff who require updates to their personal training plan. Last year, 207 training sessions were carried out with projected figures for this year sitting at 350+. Immunisation Team - as there was a possibility of the Immunisation Team being re-deployed into wards, the H&S team worked hard to deliver 10 Manual Handling Induction Courses to 80 members of staff. Initially, these members of staff came onboard as Vaccinators and at that time were not employed for patient care. Resilience measures are now in place which is a huge positive step forward. NMcC - Fantastic work from A-MM and the team as is looking forward to having new enthusiastic staff on board - please take assurance from this. A-MM - Workforce Development signpost staff to contact the Manual Handling team to arrange their individual Manual Handling training. Several members of staff have slipped through the net, however, and if the loop can be closed then training will run more smoothly overall. KR - Jackie Millen is leading on a SLWG for starters, leavers and change processes. She has spoken of a tidy up of the induction process and she described a 'one and done' style approach to new starts. **Action** KR to relay the importance of manual handling training requirements to Jackie Millen, as described by A-MM above. Moving forward, KR will ensure that A-MM is involved as part of the Induction process.	**KR/A-MM** **KR** **KR**

	A-MM – it would be helpful to have a list of new members of staff who are joining the organisation as well as staff members who require patient handling training. **Action** KR to provide A-MM with a list as described above.	**KR**
6.	**NHS Fife Enforcement Activity** There has been no recent HSE enforcement activity to report within NHS Fife. Enforcement Activity within other Boards NHS Grampian – Violence and aggression enforcement due to lack of Risk Assessments in place. NHS Highland – Manual Handling issues. NHS Grampian – Fatality with a contractor who was working on the site. HSE enforcement report as part of the investigation to follow on their website. Once the enforcement report is available, PB has advised that he will ensure that we are following compliance with the requirements that come from it. 'Signing In System' for Contractors PB - Consideration is being given to adopting a 'signing in system' both locally and nationally in order to reduce familiarity when contractors come onto any of our sites. On-going.	
7.	**Policies & Procedures** NMcC - A list has been published as part of EDG around all outstanding policies and procedures across the Board. My intention is to bring this list to the next SMT meeting. **Action** NMcC - a filtered list of outstanding H&S Policies & Procedures to be brought to the next H&S Sub-Committee meeting on 10 March 2023.	**NMcC**
8.	**Any Other Business** 8.1 Skin Health Surveillance SBAR A copy of the Skin Health Surveillance SBAR prepared by Amanda Wong, Director of Allied Health Professions was distributed to members of the group. NMcC - Amanda Wong is Chair of the Skin Health Surveillance Group and	

	this is a cross-over area between Health & Safety and Occupational Health. There are 2 asks of us: • To <u>support</u> the Skin Health Surveillance Group alongside IT to find out if there is a digital solution to this. This could be the perfect opportunity for a paper light exercise to ensure that the administrative burden is reduced as ideally wards/departments should hold their own records. KR - It is a Corporate responsibility to be able to identify records, where required. • The role of <u>Skin Co-ordinator</u> could be supported by appropriate managers within the organisation. KR – Happy to agree that this could be the way forward. Rhona Waugh, Head of Workforce Planning & Staff Wellbeing has been involved with the preparation of the paper with Amanda Wong, however, we must be cautious around the quantity of workload involved if the process is to change. **<u>The group agreed to support the paper and working alongside IT to find a technical solution to this</u>** **<u>Action</u>** NMcC to discuss the role of Skin Care Co-ordinators across the organisation with CD, JK and NC. 8.2 <u>H&S Proposed Departmental Structure 2023</u> A proposed H&S Departmental Structure 2023 was circulated to group members for information and BN advised of his staffing arrangement plans. BN added that Bill Coyne has been trained well by the HSCP before he left his post there to join NHS Fife. NMcC - happy to support the Partnership until the vacant Violence and Aggression post is filled in the HSCP. RL - Given the highest number of violence and aggression incidents occur within the LD and Mental Health Wards we will have to progress the recruitment process at some pace or come to an arrangement on an interim basis so we do not expose these areas. NMcC - Would a Fife Wide solution be helpful? **<u>Action</u>** RL will consider NMcC's suggestion and advise of her thoughts. 8.2 <u>Two members of staff involved in accidents - A&E Entrance. VHK</u>	**NMcC** **RL**

	NMcC - Wanted to highlight the incidents to the group and that only minor injuries were sustained by the staff members in question. An SBAR has been written. Not a RIDDOR reportable incident. Consideration being given to improving the surrounding environment. A-MM - The area in question does meet health and safety requirements, however, there are actions that can be put in place in order to reduce the likelihood of this happening again. PB – the area has been risk-assessed and is the process of signing-off the order to put the necessary remedials in place.	
9.	**Date & Time of Next Meeting** Friday 10 March 2023 at 12.30 pm on Teams	

INFORMATION GOVERNANCE SECURITY & STEERING GROUP

(Meeting on 31 January 2023)

Nothing to escalate to Clinical Governance Committee.

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON TUESDAY 31ST JANUARY 2023, 0900, VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy/ Deputy Chief Executive
Claire Dobson	Director of Acute Services
Susan Fraser	Associate Director of Planning and Performance
Alistair Graham	Associate Director Digital & Information
David Miller	Director of Workforce
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:	
Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance & Security / DPO
Kirsty MacGregor	Associate Director of Communications
Gillian MacIntosh	Head of Corporate Governance
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Michelle Campbell	Primary Care DPO, Digital & Information
Lorna Thomson	Senior Project Manager, Digital & Information
Apologies:	
Frances Quirk	Assistant RIK Director
Janette Keenan	Director of Nursing
Brian McKenna	HR Manager
Allan Young	Head of Digital Operations, Digital & Information,
Joy Tomlinson	Director of Public Health
Helen Hellewell	Associate Medical Director
Sharon Mullan	General Practitioner
Dr Chris McKenna	Medical Director
Nicky Connor	Director of Health & Social Care
Nicola Robertson	Associate Director of Nursing
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)

1	**CHAIRPERSON'S WELCOME AND APOLOGIES**	
	M McGurk welcomed everyone to meeting and apologies were noted.	
2	**MINUTE & ACTIONS OF PREVIOUS MEETING 11th October 2022**	
	Minutes were reviewed and agreed they were a true record and actions were discussed and updated accordingly.	
3	**MATTERS ARISING**	
	3.1 GP Data Sharing A Graham provided a brief background to item noting this has been an outstanding item from previous IG&S Steering Group and work has been undertaken by M Campbell and added improved controls. The Project has gone through consultation with areas and recommendations have been suggested and noted. M Campbell noted they are now supportive with the additional controls that have been implemented. Concerns were raised initially but these have now been resolved. M Campbell noted the recommendation in support of GPs is the initial use of Breakglass functionality, however in the future, this may not be a requirement.	

	L Thomson acknowledged the demand from clinical teams to have Primary Care data available in the Portal. Conversations are supportive in principle and assurances have been taken to protect the data and ensure audit of access is possible. We are reviewing with supplier to implement break glass. The portal does provide a full history and audit on who accessing data. If patients do not consent to their data being shared, they can opt out. The next step in our plan is to work with GP Primary Care and GP's around communications and the technical implementation L Thomson provided a brief overview of the positive benefits, noting we already share by paper readily, this is just an alternative way. A Graham provided a summary of the discussions and advised the group consideration was around the protection and audit of the data. This work is supported by the Digital and Information Board and will be presented to the Clinical Governance Oversight Group for assurance. M McGurk queried the papers noted for assurance but has decision on, clarity was sought from Information Governance perspective there are no issues. M Campbell confirmed Information Governance they are happy assuming the controls will be introduced by the project. Assurance has been sought from a data perspective we are clear and there are no issues. **Support provided.**	
4.	**IG&S ASSURANCE ACTIVITY TRACKER**	
	4.1 IG&S Activity Tracker A Graham introduced item advising this has been ongoing for the last 2 years and is grateful for the feedback received. A brief overview provided noting the Activity Tracker is divided into four domains: • Data Protection and GPDR • Freedom of Information (FOI's) • Public Records Management • NIS D **Data protection** – SLWG for SARS, work is ongoing, and progress is being made. A considerable amount of work has been undertaken regarding the assurances for assets registers. This has identified over 1100 assets which are being managed and complied with. A Graham thanked for all the hard work by Information Governance Team. **FOI's** – BAU continues, and a new framework is being revised and will be presented to EDG when completed. **NIS D** - Compliance – elements are now completed. Last two are controls through Architecture & Resilience Board (ARB) and there is a revised Procurement Policy, this will be presented to the Procurement Board. Review of legacy items and decommissioning of items. Overarching review of policies and procedures, work continuing these have been completed from an Information Governance perspective. M McGurk thanked for the paper and good to see green as the majority and clear action plans and timelines where associated.	

	M Guthrie highlighted they have asked the Commissioner for an extension timeline on the FOI's as per what was applied during Covid due to current winter pressures. M McGurk queried if this is NHS Fife or National. M Guthrie replied this is a national consideration and will report back when they received feedback. A Graham noted there are policies to be updated and they continued to be updated, further updates will be presented at the next meeting. **Action** – AG to continue progressing renewed work plan for presentation at the next meeting	**AG**
	4.2 IG&S Key Matrix A Graham noted this paper is for information only to continue with the work and to highlight where they may be gaps. Discussion was undertaken on this information in the above item.	
	4.3 Subject Access Request Update M Guthrie presented paper and noted this has been brought to group to provide assurance the programme of work is continuing and within the time framework that was expected. They are going to adopt the same model as per FOI's. A Graham advised there are a few complexities, but these are being worked through. A brief example was provided of a complaint that was received that may contain a SAR as part of the process. M Guthrie confirmed there will be significant training provided for each service and these will be run by the SLWG. M McGurk queried if a record would be taken of the training. M Guthrie clarified this will be tracked with current and new staff.	
	4.4 New Framework Update A Graham noted this is a verbal update for assurance on the current work being undertaken on the new framework. A paper will be presented at the next meeting in April. A Graham and M Guthrie attended a meeting with the Scottish Government and other groups that are leading the national review to discuss the framework, and all is going well. This will continue to satisfy the ICE report and this mechanism will pick up domains. We can evidence and provide assurance of all works continuing. This will be presented at the next meeting for consideration. M Guthrie advised they are keen for this to be part of regular updates and not just within the quarterly meeting. Work on the ToR is currently in progress and will ensure the right audience is captured. A Brown provided feedback and noted this is very positive and queried how this will tie in with NIS Audit and provide assurance to the auditor. A Graham provided feedback and noted the audits have been awarded to the same provider as previously held. A brief update was provided on the current process. We believe we are in strong position and continue to be. Conversation is continuing with the provider. No timescale has been released at present for these audits. Once these are confirmed feedback will presented.	
5	**RISK MANAGEMENT**	
	M McGurk provided feedback on the progress of the work that has been undertaken regarding Information Governance, noting there were long standing control issues and a borderline discloser but with the continuing efforts and hard work of Alistair and team they have turned around.	

	A Graham introduced paper and advised this report is for providing assurance to the Board. A brief update was provided to the paper noting the below: • There are a total of 26 risks which are actively being managed. • 8 high risks, 15 moderate and 3 low to very low risk. • 1 high risk has deteriorated (1500) this is continued to be monitored. • 11 risks have improved their status with risk 2103 going from high to a low risk. • 3 risks have been closed, 225, 1594 and 2369 • 13 DPA and GDPR risks with 2 high, 9 moderate and 2 low. A Graham provided feedback on how the risk profile is categorised and provided a brief update to some of the risks on the profile. All risks are monitored and with the target levels reviewed. Risk 1500 - Cyber Resilience Risk has been added to the Corporate Risk Register, this has deteriorated due to the current continuing cyber threats, and this continues to be monitored. A discussion was held on this risk. Assurance was provided that "deep dives" are undertaken with risks. A suggestion was noted that this group should pick a risk, review, and discuss in detail, so there is more understanding of these risks. Support was noted for this idea and A Graham suggested risks that haven't improved can reviewed. M McGurk suggested this group should see the deep dive on risk 1500 before it is seen by other committees and this to be brought to next meeting. **Action – Risk 1500 to be presented at next meeting** A Graham highlighted there is work ongoing to show these possibly digitally and more user friendly. M McGurk advised they find this presentation helpful and would like to see this replicated with the Corporate Risk Register. **Assurance** noted. No further comments were made.	**AY/AG**
6.	**DOCUMENTS FOR APPROVAL/COMMENTS**	
	6.1 Risk Appetite and Tolerance A Graham provided a background to paper. Within the NISD Audit there are controls and part of these controls are risks. One of these risks is Cyber. Within the NISD compliance NHS Fife must demonstrate that we made every effort to satisfy the following risk management profiles. These are profiles are: Policy & Processes, Cyber / Information Risk Assessment, Risk Tolerance & Treatment and Risk Governance. A Graham noted Digital Operations have rated a tolerance level to these categories and provided a brief background. We would undertake a treatment, and then bring into a risk assessment. If we were accepting of these consequences, we would then complete consequence ratings. M McGurk provided feedback and noted they would not want anything to be moderate. Concerns were raised and they believe more time requires to be spent on discussion for this item. A discussion on was undertaken on this item, with a query raised by A Brown regarding the theoretical risk proximity and is this used to calculate the target and timescale. A Graham provided feedback and noted there is an urgency on actions. Some of the cyber elements a lot of work was completed to mitigate.	

	After discussion it was decided this item is not supported and to be brought back to next meeting for further discussions. **Action – Further activities required and to be presented at next meeting**	**AG**
7.	**ITEMS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE** Group confirmed nothing to escalate	
8.	**AOCB** No other competent business was raised. M McGurk thanked all for their attendance.	
9	**DATE OF NEXT MEETING:** Tuesday 11th April 2023, 0900, via MS Teams	

RESILIENCE FORUM (Meeting on 1 December 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Resilience Forum

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

NHS Fife

unconfirmed minute of the NHS Fife Resilience Forum held on Thursday 1st December 2022 at 2.30pm via Microsoft Teams

Present:

Joy Tomlinson, Director of Public Health (Chair)	**JT**
Paul Bishop, Head of Estates	**PB**
George Brown, Emergency Planning Officer	**GB**
Susan Cameron, Head of Resilience	**SC**
Allan Young, Head of Digital Operations	**AY**
Lynne Garvey, Head of Community Care Services	**LG**
Donna Galloway, General Manager	**DG**
Craig Burns, Resilience Officer	**CB**
Kevin Reith, Director of Workforce	**KR**
Kirsty MacGregor, Associate Director of Communications	**KMcG**
Susan Fraser, Associate Director of Planning and Performance	**SF**
Brenda Ward, Personal Assistant (minutes)	**BW**
Stevie Rutherford, Personal Assistant	**SR**

ACTION

1. Welcome and Introductions

Chair opened the meeting, welcomed Craig Burns and Donna Galloway and asked for extended thanks to be passed to Andy Mackay for his contribution to the group.

2. Apologies

Apologies were received from Alastair Graham, Dr McKenna, Donna Baillie, Neil McCormick and Olivia Robertson.

3. Minutes of previous meeting (25th August 2022)

The minute of the previous meeting was approved subject to the following amendment;

- Item 12 - Date of the next meeting to be changed to 1st December 2022 **BW**

3.1 Action Tracker

The action tracker was reviewed and updated.

4. Matters Arising

4.1 Debrief Road Traffic Accident & VIE Victoria Hospital

SC provided an update on the outcomes from the Debrief on the road traffic accident at Victoria Hospital which has been reviewed as a significant near miss and agreed to circulate to the group. Chair said it was good practice to review the learnings and appreciated the discussions taking place with other partners to understand their roles. **SC**

4.2 Terms of Reference

Chair said the current and final version of Terms of Reference had been circulated with the agenda and it will be revisited next year as part of the Annual Review.

5. Resilience Governance & Assurance

5.1 BCP Position Update / Early Quarter 3 Update

SC spoke through the Emergency Preparedness Resilience & Report for Quarter 3. DG raised in relation to Test and Exercising of BCP plans that Acute Division Clinicians would require 6 weeks' notice. SC agreed to draft a report with timelines for Clinical Areas for DG to take forward to SLT for review and discussion. **SC** SC agreed to reference HSCP alongside NHS Fife in the report to demonstrate joint working and add the HSCP BCP template as an appendix. **SC**

Chair asked PB to provide SC with an organisation response in relation to lessons learned (tents and drains) on the Major Incident Testing Exercise. **PB/SC** SC agreed to incorporated into the report.

5.2 Document Control Process

SC said it has been recognised that the Resilience Team require a formal process to have documentation ratified, published and to provide a governance system for policy documents. SC described the proposed NHS Fife Resilience Document Ratification Process and agreed circulate to the forum for feedback. If approved the process would to be taken to EDG for final approval. **SC**

5.3 H&SCP - Persons at Risk Distribution Lists NHS Fife (PARD)

LG advised that a short life working group has been taken forward by HSCP to review information sharing and the group are in the very early stages of scoping. NHS Highland had provided a demonstration of their online system and the group are looking into fully investing in a platform for Fife. LG said she was hoping to report on the groups progress in 2023.

6. Acute Overview

DG updated she had taken on the role of Chair of the Hospital Control Team; the team meet every 2 weeks and have no plans to change until after the winter. No items were raised for escalation to the forum.

6.1 Planning & Performance (Winter Planning/other)

SF reported that an update on the Annual Delivery Plan (ADP) was submitted to the Scottish Government (SG) in September 2022 and included actions for the winter. These actions are reviewed through the System Flow Group and we have a separate action plan for discharges which are reported through the Executive Group. A winter planning checklist was submitted to SG and we have not received any feedback. The ADP delivery actions are monitored monthly and have been streamlined into one action plan for Strategic Planning in Fife and all information is taken from the Strategic Planning and Resource Allocation (SPRA) Programme for 23/24.

6.2 Winter Planning (Surge Capacity/BCP)

This item was covered under Item 6.3.

6.3 EPRR Health Gov. Scot. Sit Rep Returns

The group discussed internal incidents and escalation Sit Rep returns to the ERPP Health (Scottish Government Resilience Team) and the expectation from this team that if something unusual is happening they should receive a direct report from Boards, irrespective of other reports being submitted to SG. SC requested endorsement for a review of internal notification for incidents using the OPEL system and refresh of guidance on delivering escalations to ERPP. All agreed that the OPEL system is used to understand capacity within the system and escalation should be considered when at purple. It was noted that the current Sitrep was quite complex and suggested we develop our own template for escalations for internal incidents. DG raised the criteria around incidents and are

we escalating for information or support and SC agreed to clarify. DG said escalations could be added to the OPEL Action Cards.

Chair summarised firm support from the forum to seek clarification about the purpose of SitReps to ERPP (Scottish Government Resilience Team) and a review of the internal escalation which will trigger the SitReps. **SC**

6.4 SAS Overview

SC provided a verbal update on behalf of Donna Baillie advising that two SAS Trade Unions have announced their intention to proceed with industrial action. KR updated that the strike action was postponed and the timeframe for ballot closure for Trade Unions was the 12th December and 19th December 2022. It is not anticipated there will be any further action until the New Year.

7. Digital Sit Rep - Cyber Incident 5/8/22

AY provided an update on the Cyber Incident that impacted the Out of Hours Service. The Docman and eFinancial applications were quickly recovered and the Adastra application has been a little more complex. As a national user of these applications, we are asking for further assurance and we are still awaiting assurance which is concerning.

7.1 Cyber Resilience Framework/ICO

AY updated that Kathleen Bolton has been working with D&I teams on testing current plans for a Cyber-attack, our initial response and to detect and contain. Three exercises have taken place and when the plans are complete AY plans to ask the Resilience Team to carry out a Testing Exercise. D&I have applied for funding from SG and NHS plan to also invest in a Cyber Assurance Engineer to detect/contain and have the correct tools/skills. The Cyber Security Manager left at the end of the summer and Margaret Harris will be joining on 19th December 2022 which will provide long-term sustainability within the team. AY shared that NSS Cyber Security Operations Centre was having an open day at Dundee University on 15th December. AY added that Information Governance are preparing for the ISO Audit in 2023 and are seeking assistance from the organisation in tidying up the information asset register within shared areas.

8. Emergency Plans

8.1 Lockdown Framework

CB provided an overview of the Lockdown Framework which is an overarching framework for every NHS facility in Fife. The framework had been refreshed and includes; additional sections from other plans, simplified version of roles and responsibilities and the red font text is being reviewed by our Legal Office. A short life working group has been taken forward with representation from; Resilience, Security and HSCP. The forum was asked to provide feedback direct to CB by January so the framework can be ratified. KMcG asked if the internal/external communications for the Corporate Communications Team could be added and responsibility for briefing the team. SF asked if we could change the language from Manpower to Workforce. SC added that after the frameworks was ratified, Education and Training will be provided for staff and a testing and exercising of the plan would be carried out by the Security teams. **ALL**

Chair noted she was delighted with the progress that had been made updating the framework.

8.2 Severe Weather Framework

GB provided an overview of the draft Severe Weather Framework; the main purpose is to act on warnings issued from the Met Office and have a mechanism to establish a severe weather control team. The framework has been updated with information on the use of 4x4 vehicles through a group operated by volunteers and feedback has been received from the Director of Workforce and HSCP. Fife have a separate severe weather communication plan and it was agreed the framework needs to have some flexibility to include localised amber/yellow warnings. PB provided an update on the recent flooding at Cameron Hospital and has been in contact with Fife Council and is working with Diageo on an access plan. PB agreed to provide SC with information for an Action Card and agreed to meet with GB to carry out a debrief.

GB

PB/GB

Chair asked for final comments to be submitted to GB by 31st December 2022. **ALL**

8.3 Bomb Threat & Suspicious Item Response Plan

CB said the Bomb Threat & Suspicious Item Response Plan has been in place for a number of years. It has been updated based on latest intelligence from the Police and posters are being designed for distribution within our mail rooms. The forum approved the plan to progress to EDG with the Major Incident Plan in January 2023, subject to a few minor amendments.

8.4 Scientific Technical Advisor Cell (STAC)

JT said the Scientific Technical Advisor Cell (STAC) is a national framework document that supported Public Health's response during Covid. The framework has had a few amendments prior to submission to East Region and it was agreed to circulate to the forum asking for feedback by 31st December 2022. **SC**

9. Training & Exercising

9.1 HAZMAT Feedback

SC presented the document for information and included information on three visits from SG auditors and positive feedback on processes and facilitation of the event held in August 2022.

9.2 Business Continuity Testing & Exercising Program

GB said that the team have created 8 different scenarios to test plans, including supply chain, lack of utilities and lack of communications etc. SC noted the testing and exercising of plans will be short one-hour sessions delivered over teams where the Department have one scenario. The program will be a carried out annually in all Departments and requires as many staff as possible to have an awareness of BCP which will enable a gap analysis impact assessment to be carried out. SC asked forum members for the correct approach agreeing testing plans in non-clinical areas and PB recommended these testing plans would also go to SLT through Acute or alternatively speak to the General Manager for the Service. GB agreed to speak with PB to discuss approach. **GB/PB**

9.3 National Grid/Scottish Power Energy Networks

GB shared a paper from the East of Scotland Regional Resilience Partnership on Rota Disconnection which outlines how Scottish Power Energy Networks allocate electricity if there is an issue with power.

SC provided an update on the "Mighty Oak" which is a national infrastructure exercise that will test the response to national power outages. It will provide an opportunity to test the national responses and potentially how local areas will respond and communicate.
Tony Beveridge from Police Scotland is leading on developing the local approach and a multi-agency testing exercise is being arranged for early March 2023. Chair

thanked GB and SC for the updates and advised these would be incorporated into an SBAR for EDG.

10. Upcoming Significant Events

SC said a multi-agency exercise was being planned at Braefoot Bay and Resilience will attend to observe as potential for a STAC response. The exercise will include how Fife would interact in a multi-agency operability as a receiving hospital for any mass casualties. SC agreed to include the output in the EPPR Quarter 3 report.

11. Any other business

No items were raised.

12. Date of next meeting

Wednesday 1st March 2023 at 2:00pm

12.1 Schedule of meetings for 2023

Circulated to the forum for information.