NHS Fife Clinical Governance Committee

Fri 04 November 2022, 10:00 - 12:30

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Christina Cooper

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Christina Cooper

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Friday 2 September 2022

Enclosed *Christina Cooper*

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20220902.pdf (12 pages)

10:00 - 10:15
15 min

4. Matters Arising / Action List

Enclosed *Christina Cooper*

Item 04 - Clinical Governance Committee Action List - 20221104.pdf (2 pages)

4.1. Hospital Standard Mortality Rates Update Report

Enclosed *Chris McKenna*

Item 04.1 - SBAR Hospital Standard Mortality Rates Update Report.pdf (4 pages)

10:15 - 10:20
5 min

5. ACTIVE OR EMERGING ISSUES

5.1. Covid-19

Verbal *Joy Tomlinson*

10:20 - 10:40
20 min

6. GOVERNANCE MATTERS

6.1. Corporate Risks Aligned to Clinical Governance Committee

Enclosed *Chris McKenna/Janette Keenan*

Item 06.1 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (6 pages)
Item 06.1 - Appendix 1 Summary of Corporate Risks Aligned to the Clinical Governance Committee.pdf (5 pages)
Item 06.1 - Appendix 2 Assurance Principles.pdf (1 pages)

10:40 - 11:20
40 min

7. STRATEGY / PLANNING

7.1. Draft Clinical Governance Framework and Delivery Plan

Enclosed *Chris McKenna*

- Item 07.1 - SBAR Draft Clinical Governance Framework and Delivery Plan.pdf (4 pages)
- Item 07.1 - Appendix 1 Draft Clinical Governance Framework Summary.pdf (1 pages)
- Item 07.1 - Appendix 2 Draft Clinical Governance Framework.pdf (47 pages)
- Item 07.1 - Appendix 3 Draft Clinical Governance Framework Delivery Plan 2022-23.pdf (4 pages)
- Item 07.1 - Final Description clinical and care governance in HSCP.docx.pdf (3 pages)

7.2. Report on Outcomes from Existing Clinical Strategy

Enclosed *Chris McKenna*

- Item 07.2 - SBAR Report on Outcomes from Existing Clinical Strategy.pdf (4 pages)
- Item 07.2 - Appendix 1 Review of Clinical Strategy Draft Report 2016-21.pdf (17 pages)

7.3. Strategic Planning & Resource Allocation 2023/24

Enclosed *Margo McGurk*

- Item 07.3 - SBAR Strategic Planning & Resources Allocation 2023-24.pdf (3 pages)

7.4. Annual Delivery Plan Progress & Winter Actions

Enclosed *Margo McGurk*

- Item 07.4 - SBAR Annual Delivery Plan Progress & Winter Actions.pdf (5 pages)
- Item 07.4 - Appendix 1 Update on Annual Delivery Plan.pdf (12 pages)

7.5. Laboratory Information Management System Update

Enclosed *Alistair Graham*

- Item 07.5 - SBAR Laboratory Information Management System Update.pdf (9 pages)

7.6. Integrated Unscheduled Care Report

Enclosed *Chris McKenna*

- Item 07.6 - SBAR Integrated Unscheduled Care Report.pdf (3 pages)
- Item 07.6 - Appendix 1 Integrated Unscheduled Care Report.pdf (3 pages)

11:20 - 11:40
20 min

8. QUALITY / PERFORMANCE

8.1. Integrated Performance and Quality Report

Enclosed *Chris McKenna/Janette Keenan*

- Item 08.1 - SBAR Integrated Performance and Quality Report.pdf (4 pages)
- Item 08.1 - Appendix 1 Integrated Performance and Quality Report.pdf (15 pages)

8.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

- Item 08.2 - SBAR HAIRT Report.pdf (6 pages)
- Item 08.2 - Appendix 1 HAIRT Report.pdf (28 pages)

8.3. Review of Deaths of Children & Young People Interim Report

Enclosed *Janette Keenan*

Item 08.3 - SBAR Review of Deaths of Children & Young People Interim Report.pdf (9 pages)

11:40 - 11:55
15 min

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1. Patient Experience & Feedback Report - Quarter 2

Enclosed *Janette Keenan*

Item 09.1 - SBAR Patient Experience & Feedback Report - Quarter 2.pdf (15 pages)
Item 09.1 - Appendix 1 Patient Experience & Feedback Report - Quarter 2.pdf (17 pages)

9.2. Quality Framework for Community Engagement & Participation

Enclosed *Janette Keenan*

Item 09.2 - SBAR Quality Framework for Community Engagement & Participation.pdf (8 pages)

11:55 - 12:15
20 min

10. ANNUAL REPORTS

10.1. Integrated Screening Annual Report 2022

Enclosed *Joy Tomlinson*

Item 10.1 - SBAR Integrated Screening Annual Report 2022.pdf (4 pages)
Item 10.1 - Appendix 1 Integrated Screening Annual Report 2022.pdf (24 pages)

10.2. Medical Education Annual Report 2021-22

Enclosed *Chris McKenna*

Item 10.2 - SBAR Medical Education Annual Report 2021-2022.pdf (4 pages)
Item 10.2 - Appendix 1 Medical Education Annual Report 2021-2022.pdf (18 pages)

10.3. Medical Appraisal and Revalidation Annual Report 2021-22

Enclosed *Chris McKenna*

Item 10.3 - SBAR Medical Appraisal and Revalidation Annual Report 2021-22.pdf (3 pages)
Item 10.3 - Appendix 1 Medical Appraisal and Revalidation Annual Report 2021-22.pdf (8 pages)

10.4. Prevention & Control of Infection Annual Report 2021

Enclosed *Janette Keenan*

Item 10.4 - SBAR Prevention & Control of Infection Annual Report.pdf (6 pages)
Item 10.4 - Appendix 1 Prevention & Control of Infection Annual Report.pdf (49 pages)

10.5. Controlled Drug Accountable Officer Annual Report 2022

Enclosed *Ben Hannan*

Item 10.5 - SBAR Controlled Drug Accountable Officer Annual Report.pdf (3 pages)
Item 10.5 - Appendix 1 Controlled Drug Accountable Officer Annual Report.pdf (16 pages)

10.6. Volunteering Annual Report 2021-22

Enclosed *Janette Keenan*

Item 10.6 - SBAR Volunteering Annual Report 2021-22.pdf (4 pages)
Item 10.6 - Appendix 1 Volunteering Annual Report 2021-22.pdf (8 pages)

12:15 - 12:20
5 min

11. FOR ASSURANCE

11.1. Delivery of Annual Workplan

Enclosed *Elizabeth Muir*

- Item 11.1 - Clinical Governance Committee Annual Workplan 2022-23 as at 20221028.pdf (7 pages)

12:20 - 12:25
5 min

12. LINKED COMMITTEE MINUTES

12.1. Acute Services Division Clinical Governance Committee held on 7 September 2022 (unconfirmed)

Enclosed

- Item 12.1 - Cover Paper - Acute Services Division 20220907.pdf (1 pages)
- Item 12.1 - Acute Services Division Minutes (unconfirmed) 20220907.pdf (18 pages)

12.2. Area Clinical Forum held on 6 October 2022 (unconfirmed)

Enclosed

- Item 12.2 - Cover Paper - Area Clinical Forum 20221006.pdf (1 pages)
- Item 12.2 - Area Clinical Forum Minutes (unconfirmed) 20221006.pdf (3 pages)

12.3. Cancer Governance & Strategy Group held on 19 August 2022 (unconfirmed)

Enclosed

- Item 12.3 - Cover Paper - Cancer Governance & Strategy Group 20220819.pdf (1 pages)
- Item 12.3 - Cancer Governance & Strategy Group Minutes (unconfirmed) 20220819.pdf (10 pages)

12.4. Clinical Governance Oversight Group held on 16 August 2022 (confirmed)

Enclosed

- Item 12.4 - Cover Paper - Clinical Governance Oversight Group 20220816.pdf (1 pages)
- Item 12.4 - Clinical Governance Oversight Group Minutes (confirmed) 20220816.pdf (9 pages)

12.5. Digital & Information Board held on 18 October 2022 (unconfirmed)

Enclosed

- Item 12.5 - Cover Paper Digital & Information Board Minutes 20221018.pdf (1 pages)
- Item 12.5 - Digital & Information Board Minutes 20221018 (unconfirmed).pdf (8 pages)

12.6. Drugs & Therapeutic Committee held on 24 August 2022 (confirmed) & 12 October 2022 (unconfirmed)

Enclosed

- Item 12.6 - Cover Paper - Drugs & Therapeutic Committee 20220824.pdf (1 pages)
- Item 12.6 - Drugs & Therapeutic Committee (confirmed) 20220824.pdf (6 pages)
- Item 12.6 - Cover Paper - Drugs & Therapeutic Committee 20221012.pdf (1 pages)
- Item 12.6 - Drugs & Therapeutic Committee (unconfirmed) 20221012.pdf (7 pages)

12.7. IJB Quality & Communities Committee held on 9 September 2022 (unconfirmed)

Enclosed

- Item 12.7 - Cover Paper IJB Quality & Communities Committee.pdf (1 pages)
- Item 12.7 - IJB Quality & Communities Committee Minutes (unconfirmed) 20220909.pdf (7 pages)

12.8. Health & Safety Subcommittee held on 9 September 2022 (unconfirmed)

Enclosed

- Item 12.8 - Cover Paper Health & Safety Subcommittee 20220909.pdf (1 pages)
- Item 12.8 - Health & Safety Subcommittee Minutes (unconfirmed) 20220909.pdf (6 pages)

12.9. Medical Devices Group held on 16 August 2022 (unconfirmed)

Enclosed

- Item 12.9 - Cover Paper Medical Devices Group 20220816.pdf (1 pages)
- Item 12.9 - Medical Devices Group Minutes (unconfirmed) 20220816.pdf (7 pages)

12.10. Population Health & Wellbeing Portfolio Board held on 15 September 2022 (unconfirmed)

Enclosed

- Item 12.10 - Cover Paper Portfolio Board 20220915.pdf (1 pages)
- Item 12.10 - Portfolio Board Minutes (unconfirmed) 20220915.pdf (4 pages)

12.11. Research, Innovation & Knowledge Oversight Group held on 22 September 2022 (unconfirmed)

Enclosed

- Item 12.11 - RIK Oversight Group Cover Paper & Minutes (unconfirmed) 20220922.pdf (7 pages)

12.12. Resilience Forum held on 25 August 2022 (unconfirmed)

- Item 12.12 - Cover Paper Resilience Forum 20220825.pdf (1 pages)
- Item 12.12 - Resilience Forum Minutes (unconfirmed) 20220825.pdf (3 pages)

12:25 - 12:30
5 min

13. ESCALATION OF ISSUES TO NHS FIFE BOARD

13.1. To the Board in the IPQR Summary

Verbal *Christina Cooper*

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

Verbal *Christina Cooper*

12:30 - 12:30
0 min

14. ANY OTHER BUSINESS

12:30 - 12:30
0 min

15. DATE OF NEXT MEETING - FRIDAY 13 JANUARY 2023 AT 10AM

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 2 SEPTEMBER 2022 AT 10AM VIA MS TEAMS

Present:

C Cooper, Non-Executive Member (Chair)
M Black, Non-Executive Member
S Braiden, Non-Executive Member
A Haston, Non-Executive Member
K MacDonald, Non-Executive Whistleblowing Champion
A Wood, Non-Executive Member
S Fevre, Area Partnership Forum Representative
J Owens, Director of Nursing
C McKenna, Medical Director
C Potter, Chief Executive

In Attendance:

L Barker, Associate Director of Nursing (*deputising for N Connor*)
L Campbell, Associate Director of Nursing
P Cumming, Risk Manager *(item 7 only)*
C Dobson, Director of Acute Services
A Graham, Associate Director of Digital & Information
B Hannan, Director of Pharmacy & Medicines
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
E O'Keefe, Deputy Director of Public Health *(deputising for J Tomlinson)*
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting and extended a welcome to A Haston, Non-Executive Member, who is joining her first meeting of the Clinical Governance Committee following her recent appointment to the Board.

The Chair recognised the dedication of our staff and volunteers and thanked them for their ongoing hard work and effort.

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

1. Apologies for Absence

Apologies were noted from members A Lawrie (Area Clinical Forum Representative) and J Tomlinson (Director of Public Health), plus attendees N Connor (Director of Health & Social Care), S Fraser (Associate Director of Planning & Performance), G Couser (Associate Director of Quality & Clinical Governance), J Morrice (Associate Medical Director, Women & Children's Services), E Muir (Clinical Effectiveness Manager) and M Wood (Interim Associate Medical Director for Surgery, Medicine & Diagnostics).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 1 July 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.

Emergency / Resilience Planning
A Wood, Non-Executive Member, noted that the NHS Fife Resilience Forum is still referred to in the Clinical Governance Committee Terms of Reference and requested clarity that either resilience is reported through the Executive Directors' Group straight to the Board or if there is a requirement to report through the Clinical Governance Committee. The Board Secretary advised that a proposal is shortly going to the Executive Directors' Group that the Resilience Forum continues to report formally into the Clinical Governance Committee and that the Committee receives an Annual Assurance Report, similar to the existing assurance reports from the Committee's sub-groups. The Resilience Forum minutes will also be supplied to the Committee on a quarterly basis. This will shortly be reflected in the Committee's workplan once reporting dates have been agreed. No change is therefore proposed to the Committee's Terms of Reference.

Integrated Performance & Quality Report: Actions 1 - 3
It was agreed the Medical Director would address actions 1 – 2 outwith the meeting with A Wood, Non-Executive Member, and action 3 outwith the meeting with the Director of Public Health.

Action: Medical Director

Addiction Services in Fife: Action 5
The Medical Director advised that the governance route for Addiction Services is largely through the Clinical & Care Governance Committee (now the Quality & Communities Committee) which feeds into the Integration Joint Board. It was noted that Addiction Services could be a topic for a Committee Development Session. Following a statement from M Black, Non-Executive Member, regarding addiction being also a mental health issue, the Medical Director confirmed that Mental Health staff work in Addiction Services. L Barker, Associate Director of Nursing, advised that an Integration Joint Board Development Session took place recently and there was a presentation on Mental Health Services, and it had been noted at the session a further discussion is required on where Addiction Services sits within Mental Health. L Barker agreed to liaise with the team regarding presenting at a future Committee Development Session.

Action: L Barker, Associate Director of Nursing / Board Committee Support Officer

The Action List will be updated accordingly.

5. ACTIVE OR EMERGING ISSUES:

5.1 Covid-19

The Medical Director provided a verbal update and advised that the situation with managing the number of Covid-19 cases has improved.

The Medical Director advised of the potential consequences of the energy price crisis and noted that this is an emerging issue throughout the Winter that could impact on patient demand. It was reported that NHS Fife will be prepared for all scenarios, however it is expected to be challenging.

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

6. GOVERNANCE MATTERS

6.1 Annual Statement of Assurance for Clinical Governance Oversight Group

The Medical Director advised that the Annual Statement of Assurance for the Clinical Governance Oversight Group is being provided to the Committee for the first time. The Statement sets out the range of activities from the Clinical Governance Oversight Group over the previous year.

A Wood, Non-Executive Member, praised the report and requested more detail on the clinical effectiveness agenda and other key indicators, such as the quality indicator profile for mental health, stroke standards and the Scottish intensive care elements. A Wood noted that assurance to the Committee needs considered in terms of the scope and breadth of this work, along with the Scottish programmes of work around governance issues such as maternity & children and mental health.

The Medical Director reported that careful consideration is required on areas for escalation to this Committee and advised that there are other governance routes to consider, with some of the areas mentioned sitting within the Acute Services Clinical Governance Committee. It was noted minutes of these meetings are shared with this Committee, however if the Committee is unable to take assurance from the minutes, then consideration is required on the level and detail of information that would be provided. It was agreed a further discussion on governance escalation and alignment will take place outwith the meeting between the Medical Director and A Wood, Non-Executive Member.

Action: Medical Director

The Chair queried the level of absence from key attendees at meetings, given the importance of the Group. The Medical Director noted that there had been some issues with attendance at meetings, which was due to the pressures of the pandemic, and that going forward it is expected attendance levels will improve.

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

6.2 Board Assurance Framework (BAF) - Quality and Safety

The Medical Director advised that the BAF, in its current format, will be replaced by the new Corporate Risk Register going forward. The Medical Director advised that there were no significant changes to the BAF from the last presentation to the Committee.

A Wood, Non-Executive Member, highlighted the audit trail and questioned the checks and balances that will be put in place for the transition of moving to the new Corporate Risk Register, to ensure that there are no losses of information. The Director of Finance & Strategy advised that the majority of the detail associated with the BAF will remain in the system, and that the new Corporate Risk Register will present the same information in an alternative and focussed way, to allow more meaningful discussions and deep dives. Assurance was provided that the Chief Internal Auditor has been working closely with the team on the development of the new Corporate Risk Register, to provide scrutiny and challenge.

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

6.3 Board Assurance Framework (BAF) - Strategic Planning

The Director of Finance & Strategy advised that the moderate level of risk has not changed. Within the Corporate Risk Register, the description of the risk has been changed to reflect the effectiveness and delivery of the strategy.

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

6.4 Board Assurance Framework (BAF) - Digital and Information

The Associate Director of Digital & Information advised that the Cyber Resilience Risk has been added as a linked risk and is aligned with the four objectives of the Cyber Resilience Framework.

A Wood, Non-Executive Member, queried the associated risk for Laboratory Information Management System (LIMS), noting it was not visible on the BAF, despite recent Board-level discussions on this issue. The Associate Director of Digital & Information advised that the risk is currently sitting within the operational area of Digital & Information, and consideration will be given to including it within the Corporate Risk Register.

Following a question from the Chair on the financial position, the Associate Director of Digital & Information advised of an improved position, noting that the ongoing demand for digital investment still needs to be confirmed. It was also advised that the decision on demand is linked to the outcomes of the Public Health & Wellbeing Strategy development work and the engagement that is being carried will inform that decision.

The Committee **noted** the content and current assessment of the Digital & Information BAF for **assurance**. The BAF's current risk level has been assessed as High, with the target score remaining moderate.

7. RISK

7.1 Corporate Risk Register

The Director of Finance & Strategy advised that the paper is being presented to all the Governance Committees at their September meetings, for onward submission to the full Board on 27 September 2022.

The Director of Finance & Strategy provided background detail and advised that the main focus of the new Corporate Risk Register was the presentation, opportunity for scrutiny and consequential impacts of the risks.

An explanation was provided on the 'Strategic Risk Profile' and 'Risk Improvement Trajectory & Deep Dive into deteriorating risks' graphics, at annex 1. It was advised that detailed scrutiny and deep dive areas will be identified. It is proposed that there is also a high-level summary statement, which would be drafted on behalf of the Chief Executive and would form part of the Chief Executive's key message on the overall position. The Director of Finance & Strategy noted that for deep dives identified, the Executive Lead would be expected to present on the risk and mitigations. It was reported that at the recent Board Development Session, a deep dive was carried out on cyber resilience. It was noted formal reporting outcomes of deep dives, and any potential changes in terms of risk levels, is under consideration.

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It was advised that an operational Risk & Opportunities Group has been formed, with positive engagement, and they will carry out detailed scrutiny and challenge the Corporate Risk Register before consideration at Committee level.

The Director of Finance & Strategy advised that the next iteration of the Corporate Risk Register will include the previous risk profile to identify the movement between reporting periods.

The Director of Finance & Strategy advised that 18 strategic risks have been identified within the Corporate Risk Register, detailed at annex 2. It was noted that the 18 risks are at strategic or corporate level, and that the Board need to be assured risks are being managed at an operational level. Feedback was requested from the Committee on whether the 18 strategic risks identified are the key challenges and risks that the organisation is facing. It was also questioned if the description of the risks has improved and if there is anything missing that should be included.

The Medical Director noted that the some of the risks are significant and broad, and questioned if the 'Risk Owner' is the correct term. The Director of Finance & Strategy advised that all the risks relate to corporate objectives, which have a designated Executive Lead, and that this has been replicated in the Corporate Risk Register. It was noted agreement can be made on the overall lead for the risks, if required.

A Wood, Non-Executive Member, commended the work and the concept of the deep dives. She highlighted that 10 of the 18 risks sit with the Clinical Governance Committee and requested that all risks are reviewed to ensure an appropriate spread across the Board's governance structure. A Wood also noted consideration will need to be given to the risks that sit in other areas in terms of the clinical governance aspects. The Director of Finance & Strategy advised that there are a number of risks

that are being proposed to sit within the Clinical Governance Committee and that the Finance, Performance & Resources Committee also have a locus on these risks. It was agreed to review and discuss further at the Executive Directors' Group, with a view to concluding before the Corporate Risk Register is presented to the September Board meeting.

Action: Director of Finance & Strategy

S Fevre, Area Partnership Forum Representative, offered to provide some comments regarding the 'Whole System Capacity' risk, which was welcomed.

Action: Area Partnership Forum Representative

Following a question from the Chair, the Director of Finance & Strategy advised that the Committee should be aware that risks need to be identified in the context that is currently being operated in as a Clinical Governance Committee. It was also advised that the Committees and Board members should be aware that we have a risk around the delivery of a balanced in-year financial position. It was noted that there should be no risks on the Corporate Risk Register that the Committee have not had sight of.

The Committee thanked all involved for their hard work in the development of the Corporate Risk Register.

The Committee took **assurance** from the work to date on developing the Corporate Risk Register and Dashboard reporting.

7.2 Development of Assistant Practitioner Role

The Director of Nursing spoke to the paper. It was advised that a Board Development Session took place on 31 August 2022, and the development of the Assistant Practitioner role was discussed. This item has also been discussed at the recent Staff Governance Committee and will also be discussed at the Finance, Performance & Resources Committee at their September meeting.

Following a question from A Wood, Non-Executive Member, the Director of Nursing confirmed that Band 5 roles will not be replaced by Band 4 roles. There will be opportunity for Band 4 Assistant Practitioners to carry out training and progress to become Registrants. It was noted there has been a significant drop, compared to the previous year, in the number of people applying to become Registrants.

The Director of Finance & Strategy advised more detailed discussions around the financial framework is required through the Finance, Performance & Resources Committee. Assurance was provided that the budget available for Band 5 staff will be maintained at a level which allows all possible recruitment. It was noted agency work is not always the most effective way to recruit staff.

The Chief Executive noted that the focus for the development of the Assistant Practitioner role will change slightly for each Committee and added that a thorough discussion took place at the Staff Governance Committee held on 1 September 2022 on the Staff Governance Standards aspect. Further work will be carried out in relation to engagement with our Band 5 workforce. The financial aspects will take place through the Finance, Performance & Resources Committee for scrutiny.

L Campbell, Associate Director of Nursing, gave assurance and provided detail on the validated tools. Assurance was also provided that there is an associate professional judgement tool which allows the organisation to look at dynamics within areas and the change in clinical delivery that is required, and it also provides the skill mix most appropriate to carry that out. It was noted this is an annual process that forms part of the legislation about to be implemented, and the process can be carried out at any point in the year.

S Fevre, Area Partnership Forum Representative, questioned the accountability and responsibility of Band 5 roles, from a clinical aspect. It was also questioned where the new roles will be allocated. The Director of Nursing advised that accountability and delegation forms part of the learning for Registrants and the Professional Assurance Framework. It was noted that the new roles will support and release pressure from the Registrants, as they will be able to take accountability and delegation for some of the Band 2 to Band 4 roles. The Director of Nursing advised that Fife College have advised that there are 25 spaces for the first cohort and the new roles will be prioritised across Fife, linking in with Acute Services and the Health & Social Care Partnership.

L Barker, Associate Director of Nursing noted that a robust engagement plan is under development.

Following a question from M Black, Non-Executive Member, regarding international recruits, the Director of Nursing advised that NHS Fife is working closely with the Centre for Workforce Supply around international recruitment. It was also advised that there is a Memorandum of Understanding with Yeovil Trust, who are an experienced Trust in terms of international recruits, and that international recruits that are coming to NHS Fife via Yeovil Trust are mainly from India and the Philippines.

M Black, Non-Executive Member, questioned if we need to review our service models, suggesting some of the services could move to the voluntary sector. The Director of Nursing advised that some services models are being reviewed and it is likely that this will discontinue as we go forward.

Following a question from M Black, Non-Executive Member, on the clinical aspect, the Chief Executive advised that there was a challenge from the Staff Governance Committee around the extent of the engagement carried out with our workforce. The Chief Executive also advised that she raised concern at the Staff Governance Committee that if there was a reluctance to proceed with the development of a Band 4 role, then the Staff Governance Committee had to be prepared to accept the clinical risks of not having a workforce as we move into Winter. The Chief Executive added that the Staff Governance Standards were queried at the meeting, and if assurance on our engagement could be offered that the Standards were being met.

The Director of Nursing highlighted the career development pathways, which will hopefully increase our pipeline. S Fevre, Area Partnership Forum Representative, questioned any potential additional support for Registrants. The Director of Nursing advised that close communication and engagement will be carried out with nursing teams, and the Practice Development Nurse will also be closely involved.

The Medical Director recommended that the Committee take assurance from this development and the assurance around the educational aspect. The Medical Director

also recommended that the Committee take assurance that senior staff are exploring supporting staff in clinical areas throughout the Winter to address the exceptional risk.

The Committee **noted** the contextual information and took **assurance** that the Assistant Practitioner role is being progressed with staff, financial and clinical governance aspects in mind.

8. QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report (IPQR)

The Director of Nursing spoke to the Clinical Governance section with the IPQR.

A Wood, Non-Executive Member, raised concern that the narrative for the in-patient falls and the reference to staffing issues and Covid factors which are impacting on the number of in-patient falls, has not changed over a long period of time. No changes in the narrative around complaints was also highlighted.

A Wood, Non-Executive Member, also highlighted the number of people who have experienced major/extreme harm or moderate harm and sought assurances on outcomes and on the work that is being carried out to reduce the number of falls, including those that were preventable.

L Barker, Associate Director of Nursing, agreed to look at the narrative that is included in the report going forward to provide greater assurance.

Action: L Barker, Associate Director of Nursing

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

8.2 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing outlined the key points in the Infection, Prevention & Control Priorities report, as detailed in the paper.

The Director of Nursing reported on the Healthcare Improvement Scotland Infection Prevention and Control Standards (2022) and advised that further updates will be provided to the Committee as the actions progress for each of the new Standards.

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

9. DIGITAL/INFORMATION

9.1 Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme

The Director of Pharmacy & Medicine provided a verbal update and advised that the Board had approved the full business case for HEMPA, and progress since then has been positive. The Programme Board recently met and had advised that the contract negotiations in relation to the new supplier is well underway. Advanced planning is ongoing in terms of the delivery of the discharge element and the pharmacy stock control solution, which will enable the foundations to be built. It is expected progress

for both elements, in terms of implementation, will be this financial year, which will allow us to commence the pilot in late Spring 2023.

The Director of Pharmacy & Medicine reported that progress has been made on recruiting teams, advanced planned resource, Terms of Reference, and governance structures.

A written update will be provided to the Committee at its next meeting.

The Committee **noted** the update.

9.2 Information Governance and Security Steering Group Update

The Associate Director of Digital & Information spoke to the paper and advised that there is a defined risk appetite for the organisation that will allow the Information Governance & Security Steering Group to carry out work in relation to its responsibilities. It was noted that it is expected that the risk appetite will change from low for cyber security.

The Associate Director of Digital & Information highlighted that whilst we are in an improving position for assuring measures, the position is not yet final.

M Black, Non-Executive Member, queried the number of Freedom of Information (FOI) requests that are received on a monthly basis. In response, it was advised that the number is variable and amounts to circa 80 – 100 per month, throughout the whole organisation. The Associate Director of Digital & Information agreed to provide a summary on the FOI requests and share with the Committee.

Action: Associate Director of Digital & Information

A Wood, Non-Executive Member, queried why there is no risk associated with FOIs. It was advised that the resourcing which was added in June 2022 impacted positively on the risk, however it was noted that there be some residual risk in terms of the operational pressures and that this would be considered.

Action: Associate Director of Digital & Information

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

10 PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

10.1 Patient Experience & Feedback Report - Quarter 1

The Director of Nursing spoke to the paper and advised that a new Head of Patient Experience is now in post.

The Patient Experience and Feedback Quarterly Report was shared with members separately just before the meeting. The Director of Nursing apologised for the lateness of circulation and agreed to discuss any aspects of the report outwith the meeting, should Committee Members have any queries.

The Director of Nursing highlighted from the Patient Experience and Feedback Quarterly Report, that there were 191 care opinion posts over the quarter, and 7,500 views. Almost 80% of the care opinions were positive and complimentary around the service that people had received. A reduction in the complaints, compared to the previous quarter, was reported, and it was noted that the average length of time to respond to complaints has improved. It was reported that work is ongoing with the Organisational Learning Group to improve the number of compliments and reduce complaints. An overview was provided on the reasons for complaints, which are detailed in the report.

The Chair questioned if there will be more investment in staff within the Patient Experience Department. The Director of Nursing outlined the work that is ongoing in the background and noted that some staff who were part of the Test & Protect Team have been seconded to the department.

M Black, Non-Executive Member, highlighted the improvement with complaints, noting this is positive.

The Chief Executive provided assurance that benchmarking of the team against other areas in Scotland is underway and that this will link into the ways of working, processes and process mapping.

K MacDonald, Non-Executive Whistleblowing Champion, suggested the narrative within the IPQR is referenced to within the Patient Experience and Feedback Quarterly Report, and to also provide more information on outputs and outcomes. The Director of Nursing advised that this work is ongoing.

The Committee **noted** the report.

11. ANNUAL REPORTS

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

The Director of Nursing spoke to the paper. Assurance was provided that strategies have been reviewed and references updated within the report.

A Wood, Non-Executive Member, questioned if there are any measure dashboards associated with the framework. The Director of Nursing advised that there is an Excellence in Care dashboard that includes the quality issues. It was also reported that a survey was carried out the previous year on the Professional Assurance Framework and, due to a lack of learning opportunities during the pandemic, it was felt there would be no benefit to carry out another survey this year, however it will be considered in 2023. It was also noted that updates are provided to the Director of Nursing on a monthly basis and include Personal Development Plans, lapses in registrations and suspensions.

The Committee **noted** and **took** assurance from the contents of the paper.

11.2 Occupational Health Annual Report

S Braiden, Non-Executive Member, advised that this report was a substantive item at the Staff Governance Committee held on Thursday 1 September 2022 and was well received.

The Occupational Team were thanked for all their hard work.

The Committee **noted** the report.

12. FOR ASSURANCE

12.1 Delivery of Annual Workplan

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

12.2 Proposed Clinical Governance Committee Meeting Dates 2023/24

The Committee **approved** the Committee meeting dates for 2023/24.

13. LINKED COMMITTEE MINUTES

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

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

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

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

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

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

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

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

13.8 Fife IJB Clinical & Care Governance Committee held on 5 July 2022 (unconfirmed)

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

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

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

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

A Wood, Non-Executive Member, requested feedback on the violence and aggression incidents discussed at the Clinical Governance Oversight Group, and also around the RIDDOR reportable incidents in relation to physical assault, noting that this had been flagged for escalation. It was noted that some minutes do not have an escalation of issues cover paper, and the importance was highlighted, for assurance, of providing this to the Committee. The Medical Director agreed to take this forward with the Associate Director of Quality & Clinical Governance.

Action: 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

There were no matters/issues to escalate to the Board.

15. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 4 November 2022 at 10am via MS Teams.

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 4 November 2022

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.	**JT**	November 2022	In progress. JT is liaising with the Lead for Adverse Events.	In progress
2.	02/09/22	**Addiction Services**	To liaise with the team regarding presenting at a future Committee Development Session on Addiction Services.	**LB/HT**	A future Development Session	Date tbc.	In progress
3.	01/07/22	**Organisational Duty of Candour**	To arrange for a section to be built into the Organisational Duty of Candour Report 2021/22 around improving resilience. The 2021/22 report to be brought back to this Committee.	**CM**	13/01/23	10/08/22 - There is an adverse events improvement plan underway with an update going to Clinical Governance Oversight in August 2022. A proposal on addressing the backlog will likely be ready for the first CGC in 2023. Duty of Candour Interim Report expected before year end, with a view to concluding in Q1, 2023. Report will go to CGC meeting in January, and then on a yearly basis.	In progress / deadline not reached
4.	02/09/22	**Corporate Risk Register**	To review and discuss further, the risks that sit in other areas in terms of the clinical governance aspects, at the Executive Directors' Group, with a view to concluding before the Corporate Risk Register is presented to the September Board meeting.	**MM**	September 2022	Complete.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
5.	02/09/22		To provide some comments regarding the 'Whole System Capacity' risk.	**SFe**	September 2022	Complete.	Closed
6.	02/09/22	**IPQR**	To look at the narrative that is included in the report going forward to provide greater assurance.	**LB**	04/11/2022	Complete.	Closed
7.	01/07/22	**IPQR**	To bring an update back to the Committee from the Resuscitation Committee in relation to the level of performance for cardiac arrest.	**CMcK**	September 2022	Discussed at the Clinical Governance Oversight Group. Minutes enclosed with Committee papers (section 7 of the Clinical Governance Oversight Group minutes).	Closed
8.	01/07/22		To take forward with the Medical Director the agreement of a timeline for an update to be brought to the Committee on the Hospital Standard Mortality Rates (HSMR).	**CMcK**	September 2022	On agenda.	Closed
9.	02/09/22	**Freedom of Information Requests**	To provide a summary on the FOI requests and share with the Committee.	**AG**	04/11/22	Circulated with November Committee papers.	Closed
10.			To consider the residual risk for FOIs in terms of the operational pressures.				
11.	02/09/22	**Linked Committee Minutes**	To take forward with the Associate Director of Quality & Clinical Governance, that some minutes do not have an escalation of issues cover paper.	**CM**	04/11/22	Reminder was sent out to Secretaries to provide a cover paper for linked minutes which has been approved by the Chair of that meeting.	Closed
12.	03/11/21	**Clinical Governance Framework**	An update on the framework and delivery plan to be brought back to the Committee.	**GC**	~~29/04/22~~ ~~01/07/22~~ 31/10/22	On agenda.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Hospital Standardised Mortality Rate (HSMR) Update Report**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides:

- A summary of what Hospital Standardised Mortality Ratio (HSMR) is used for;
- An overview of HSMR in NHS Fife for the period April 2021- March 2022 and;
- An update as to how HSMR methodology has been updated in view of the pandemic

2.2 Background

HSMR data takes into consideration the factors which are recognised to affect the risk of death. Public Health Scotland collate and oversee HSMR data at a national level. The case mix of patients between different hospitals varies and as such the HSMR data is

adjusted to allow comparison between hospitals. This approach is more effective than using crude mortality rates as a means of bench marking across Scotland.

The HSMR data is calculated using records which relate to acute inpatient and day case admissions (SMR01 coded data). Data excludes obstetric and psychiatry specialities. Any death with occurs within 30 days of hospital admission is included in the data. If the HSMR value is less than 1.0 this means that the number of deaths is less than predicted, if the value is more than 1.0 this means the number of deaths is more than predicted. It is important to note that the data does not account for deaths that were unavoidable or expected.

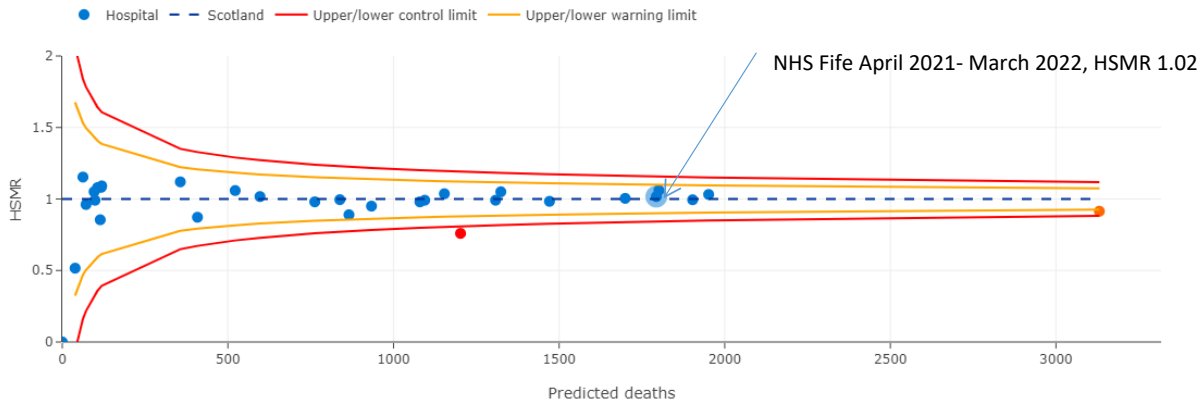
NHS Fife monitors HSMR as one of the key quality performance indicators for safety and quality. HSMR data is published in the Integrated Performance and Quality Report (IPQR).

2.3 Assessment

HSMR in NHS Fife

The HSMR for NHS Fife during 2021-2022 was 1.02 which provides assurance that the local mortality ratio was at level in keeping with the national average and in keeping with the local HSMR levels (as demonstrated in chart 1).

Chart 1.
HSMR for deaths within 30 days of admission by hospital: April 2021 to March 2022



*Note that data is representative of Victoria Hospital only as the Queen Margaret Hospital does not include any acute wards.

The NHS Fife data for this period is summarised below:

Period	Hospital	Observed Deaths	Predicted Deaths	Patients	HSMR	Crude Mortality Rate (%)
April 2021-March 2022	Victoria Hospital	1823	1793	29941	1.0	6.1

The PHS HSMR report 2021-2022 highlighted two main points:

- No hospitals had a significantly higher standardised mortality ratio than the national average
- One hospital had a significantly lower standardised mortality ratio than the national average: Western General Hospital (0.76)

The PHS Report 2021-2022 can be accessed via the following link:
https://publichealthscotland.scot/media/14472/hsmr-report.pdf

HSMR Methodology

PHS regularly reviews the HSMR methodology. In view of the COVID-19 pandemic the HSMR methodology was updated in August 2019 to include COVID-19 codes. Consequently HSMRs published after August 2019 cannot be compared to earlier publications. This provides assurance that

2.3.1 Quality/ Patient Care

Proactive review of HSMR data combined with other clinical governance quality performance indicators is fundamental to ensuring the assessment and monitoring of quality and safety.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

HSMR data demonstrates that patients domiciled in the least deprived areas of Scotland have lower levels of 30 day mortality post admission compared with the more deprived areas.

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 developed in consultation with Dr Chris McKenna (Medical Director, NHS Fife), Janette Owens (Director of Nursing NHS Fife) and Chair of the Clinical Governance Committee.

2.4 Recommendation

The Clinical Governance Committee are recommended to:

- Note the update provided;
- Take assurance that HSMR is monitored as a key quality performance indicator; and
- Take assurance that the HSMR for NHS Fife is in keeping with the national average.

Report Contact

Gemma Couser
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Corporate Risks Aligned to Clinical Governance Committee**
Responsible Executives:	**Dr Chris McKenna, Medical Director, and Janette Keenan, Director of Nursing, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance
- Discussion

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 to the Committee as part of the first cycle of reporting to the governance committees on the corporate risks, following Board approval on 27 September 2022. The content reflects the baseline starting position for launching our new approach. This report will evolve and be refined over time.

The Committee is invited to:

- Note the Corporate Risks as at 20 October 2022 set out at Appendix 1;
- Review the updates provided and consider the Assurance Principles set out at Appendix 2;
- Consider and be assured of the mitigating actions to improve the risk level; and
- Identify which risks are requested for a deep dive at the next Committee

2.2 Background

As part of the refresh of the Risk Management Framework, a Corporate Risk Register has been agreed which aligns to our 4 strategic priorities. This allows us to present the corporate risks in a manner which facilitates effective and focused scrutiny.

This approach will create the conditions for deeper conversations around assurance on the effectiveness of mitigations in terms of:

- relevance
- proportionality
- reliability
- sufficiency

This will be particularly important for risks which are deteriorating or static over time.

2.3 Assessment

NHS Fife Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite	Summary Statement on Risk Profile
To improve health and wellbeing	5	3	2	-	-	◀ ▶	High	The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite. Mitigations are in place to support management of risk over time with some risks requiring daily assessment. Assessment of corporate risk performance and improvement trajectory is in place.
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	◀ ▶	Moderate	

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 1 below and at Appendix 1. Please note:

- the content of the risk register will be reviewed and developed as appropriate between each committee cycle, with consideration at the Risks and Opportunities Group and recommendations to the Executive Directors' Group (EDG);
- the risk target levels are under review to ensure they reflect the level to be achieved at year end (i.e. March 2023)

To this end, EDG reviewed the register on 20 October 2022 and agreed:

- Realignment of the following risks to committees where the subject is reported:
  - Whole System Capacity - from the Clinical Governance Committee (CGC) to the Finance, Performance & Resources (F,P&R) Committee

- Access to Outpatient, Diagnostic and Treatment Services - from the CGC to the F, P&R Committee
- Cancer Waiting Times - from the CGC to the F,P&R Committee
- Primary Care Services - from the CGC to the Public Health & Wellbeing (PHWB) Committee

- Risks with dual owners should be allocated to a single owner:
  - Risk 5 - Optimal Clinical Outcomes - Risk owner confirmed as the Medical Director
  - Risk 10 - Primary Care Services - Risk owner confirmed as the Director of Health & Social Care
- Risk 1500 - Cyber Resilience: Change to risk target. Following discussion at EDG and subsequently with the Associate Director of Digital and Information, the target risk level is to be increased from Low 6: Likelihood - Unlikely 2 x Consequence - Moderate 3 **to** Moderate 12: Likelihood - Likely 4 x Consequence - Moderate 3. The rationale for this re- assessment is as follows. With regard to consequence, the more we exercise our response plans and technical recovery, we reduce the time for recovery, and so there is less consequence to the organisation. Regarding likelihood, it is considered necessary and realistic to increase it to more accurately reflect the current external threat level.

Governance Committees and Aligned Corporate Risk Overview

Table 1 Risks aligned to the Clinical Governance Committee

Strategic Priority	Overview of Risk Level	Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	2 - - -	◀▶	• COVID 19 Pandemic • Optimal Clinical Outcomes	• Optimal Clinical Outcomes - Ownership formerly shared between Director of Public Health and Medical Director; now allocated solely to latter. • Cyber Resilience : Risk Target changed from Low 6 to Moderate 12
To improve the quality of health and care services	1 - - -	◀▶	• Quality and Safety	
To deliver value and sustainability	2 1 - -	◀▶	• Off Site Area Sterilisation and Disinfection Unit Service • Cyber Resilience • Digital and Information	

Deep Dive Review of Corporate Risks

An objective of the new approach is to enable better scrutiny of our corporate risks. To achieve this, deep dive reviews will be commissioned for risks:

- identified by the governance committees
- identified by EDG
- considered by the Risks & Opportunities Group with recommendations into EDG

As this is the first cycle of reporting on the corporate risks, a decision was taken to carry out a deep dive review on the Cancer Waiting Times risk which was originally aligned to this Committee. In the interim, and as reported above, it has been agreed this risk is to be realigned to FP&R. The deep dive is therefore provided to this Committee for illustrative purposes only.

Members will be asked to identify deep dive (s) to be reported to the Committee from its first meeting in 2023. The Committee work plan will be developed to reflect same.

Corporate Risk Selected for "Deep Dive"

This section provides details of root cause (s) and management actions associated with the required mitigations.

Corporate Risk Title	**Cancer Waiting Times**		
Strategic Priority	To improve the quality of health and care services		
Risk Description	There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times (CWT) 62-day performance.		
Root Cause	Increased Numbers of Patients Referred with Urgent Suspicion of Cancer (76% increase in urgent suspicion of cancer referrals between 2017 and 2021) Increased complexity of cancer pathways – with more complex diagnostic pathways as a result of stratified models of care. Increasing complexity of treatment options to deliver targeted care e.g. robotic surgery options, expanding systemic anti cancer treatment (SACT) options Increased number of patients living with a cancer diagnosis with care now more akin to long term disease management , fantastic for our patients but places strain on capacity required for ongoing and follow up care (outpatient, inpatient and diagnostic capacity) People diagnosed with cancer is increasing due to the growing and aging population There is a clear link between deprivation and cancer diagnosis- cancer incidence is 30% higher in the most deprived areas compared to the least deprived areas. Around 40% of cancers are thought to be preventable. With lifestyle choices including smoking, diet and alcohol consumption is some of the key determinants.		
Current Risk Level	**15**	**Likelihood** **5**	**Consequence** **3**
Target Risk Level (in year delivery)	**12**	**Likelihood** **4**	**Consequence** **3**
Management Actions (current)			
Action		**Status**	
Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified.		**On Track – ongoing**	
A national Short Life Working Group (SLWG) is being set up to develop a 'Once for Scotland' approach to management of breaches standard operating procedure. This will be led by the NHS Fife Cancer		**On Track – Dec 2022**	

Transformation Manager (Chair of National Cancer Managers' Forum). 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	
Establishment of Acute Cancer Services Delivery Group. The purpose of this group is to ensure the routine operation of Cancer Services in NHS Fife Acute Services Division is managed effectively. It will provide assurance and highlight any exceptions to performance, waiting times, and quality standards and systems resilience.	**Delivered - ongoing**
Investment of non-recurring cancer waiting times funding from Scottish Government, allowing for short term investment to increase capacity. The Executive Director's Group has also supported use of this funding for recurring posts to support service sustainability.	**On Track**
Pilot of NHS Fife Early Cancer Diagnostic Centre (ECDC) now known as Rapid Cancer Diagnostic Service (RCDS) now supporting a rapid diagnostic pathway for patients with vague or concerning symptoms	**Delivered- ongoing operational delivery**
Patient Tracking List Meeting to escalate patients at risk of breaching waiting times	**Delivered - Ongoing operational delivery**
The implementation of Single Point of Contact Hub (SPOCH) piloting centralised support for urological and bowl cancers. SPOCH aims to improve patient experience by providing a central contact point for contact for patients going through a cancer pathway. This supports patient experience and also helps with early identification of potential delays before they are picked up at the patient tracking meeting.	**Delivered - Sept 2022**
Management Actions (future)	
Action	**Status**
The Cancer Framework and delivery plan is almost complete. Optimal Pathways and integrated care are included in the framework along with viewing CWT targets as a minimum standard. Lung and prostate have been selected as pathways for priority review (lung and prostate are amongst the 5 most common cancers in Fife).	**On Track - March 2023**

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

2.3.1 Quality / Patient Care

Effective management of risks 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

This paper does not generate specific issues of Equality and Diversity.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not generate issues related to Climate Emergency & Sustainability.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement over time, most recently at EDG on 20 October 2022.

2.3.8 Route to the Meeting

EDG on 20 October 2022, and the Medical Director and Director of Nursing on 27 October 2022

2.4 Recommendation

- Assurance
- Discussion

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 October 2022
- Appendix No. 2, Assurance Principles

Report Contact
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Appendix 1

Summary of Corporate Risks Aligned to the Clinical Governance Committee as at 20 October 2022

To improve health and wellbeing

	Risk	Mitigation	Risk Level	Target Risk Level by Mar 2023	Risk Level Trend	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 hospital care and	Delivery plans are being developed for the autumn/winter vaccination campaign. The proposed start date is early September 2022; some planning is pending Joint Committee on Vaccination and Immunisation (JCVI) decisions. Implementation of new treatments for individuals at higher risk of adverse outcomes. Public communications programme to raise awareness of infection prevention and control measures across the region population cross the population.	High 16	Mod 12	◄►	Director of Public Health	Clinical Governance

	severe disease ,including death in a minority of the population.						
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 15	Mod 10	◀ ▶	Medical Director	Clinical Governance

	To improve the quality of health and care services						
	Risk	**Mitigation**	**Risk Level**	**Target Risk Level by Mar 2023**	**Risk Level Trend**	**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	◄►	Medical Director	Clinical Governance

To deliver value and sustainability

	Risk	Mitigation	Risk Level	Target Risk Level by Mar 2023	Risk Level Trend	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 robotic being planned	Mod 12	Low 6	◄►	Director of Property & Asset Management	Clinical Governance
17	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full	Considerable focus continues in 2022 with heightened threat level to improve our resilience to attack and ability to recover quickly.	High 16	Mod 12	◄►	Medical Director	Clinical Governance

	health service.						
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	Mod 10	◄►	Medical Director	Clinical Governance

Assurance Principles, Developed by NHS Lanarkshire

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:	**4 November 2022**
Title:	**Draft Clinical Governance Framework and Delivery Plan**
Responsible Executive:	**Dr Chris McKenna, Medical Director and Janette Owens Director of Nursing**
Report Author:	**Gemma Couser, Associate Director for Quality and Clinical Governance**

1 Purpose

This report is presented for:

- Assurance
- Discussion
- Decision

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- 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

This paper and associated appendices provides an overview of the:

- Draft Clinical Governance Framework; and
- Draft Clinical Governance Delivery Plan

2.2 Background

The Clinical Governance Strategic Framework is fundamental to set out our aim of delivering safe, effective, patient-centred care as an organisation which listens, learns and improves. The Framework has been designed to ensure alignment with our 4 strategic priorities.

2.3 Assessment

Delivering Our Aim

The draft Clinical Governance Framework is set out in appendix 2. The framework sets out how our aim will be achieved through (see framework summary in appendix 1):

Our organisational values	Clinical Governance Activities	Enablers
○ Care and compassion ○ Dignity and respect ○ Quality and Teamwork ○ Openness, honestly and responsibility	○ Ensuring clinical guidelines and policies are up to dates ○ Clinical effectiveness and audit ○ Risk Management ○ Patient centredness ○ Quality Improvement ○ Reviewing and learning from incidents and legal claims ○ Organisational learning ○ Quality assurance ○ Quality performance indicators	○ Clear governance structures ○ Clear roles and responsibilities ○ Our workforce ○ Digital an information ○ Research, Innovation and Knowledge ○ Annual delivery plan

Developing the Framework

The framework has been developed with contribution from key stakeholders across NHS Fife. Early in 2022 the framework was shared in draft and key stakeholders asked to provide comments back by way of a Forms Questionnaire. Key themes identified through the 18 engagement returns were:

- The need to provide practical examples of clinical governance activities
- Summarising our quality performance indicators (QPIs)
- A requirement to make the document more accessible for ease of reading
- Clarity of reporting for key audits and QPIs

Further to this feedback the framework has been updated to address the feedback provided.

One of the areas requiring further clarity is the newly established Clinical and Care Governance Structures within the Health and Social Care Partnership (HSCP). It should be noted that the HSCP structures are stated in draft in the framework whilst clarity is sought with the HSCP Senior Leadership Team.

It should also be noted that the document will undergo a final edit by the Digital and Graphic Design Team once the content has been agreed.

Annual Delivery Plan

Appendix 3 sets out the annual delivery plans for 2022/2023. Whist the framework has been under development key workstreams have been progressed to ensure delivery of our aim. The Clinical Governance Oversight Group will provide oversight of the delivery plan. The delivery plan will be refreshed on an annual basis.

2.3.1 Quality / Patient Care

Quality and patient care is at the heart of this framework- please refer to appendices.

2.3.2 Workforce

The wellbeing and contribution of workforce is a key to this framework – please refer to appendices.

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

This framework aims to mitigate the Quality and Safety corporate risk.

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Clinical Governance Framework has been developed through:

- The Clinical Governance Oversight Group
- Discussion with Executive Leads and Chair of the Clinical Governance Committee
- Feedback from key stakeholders

2.3.8 Route to the Meeting

- Executive Directors' Group on 6 October 2022
- Clinical Governance Oversight Group on 18 October 2022

2.4 Recommendation

- Review the substance and content of the framework and associated delivery plan;
- Provide feedback on areas for improvement; and
- **Approve** the draft Clinical Governance Framework & Delivery Plan 2022/23

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Draft Clinical Governance Framework Summary
- Appendix 2, Draft Clinical Governance Framework
- Appendix 3, Draft Clinical Governance Framework Delivery Plan 2022/23

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Clinical Governance Framework

An enabling framework which aligns to our strategic framework priorities to

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

Our Aim

Delivering safe, effective, person-centred care as an organisation that listens, learns and improves

Our Values

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

Clinical Governance Activities

Ensuring clinical guidelines and polices are up to date, Clinical Audit, Risk Management, Person-Centredness, Quality Improvement, Reviewing and learning from incidents and legal claims, Organisational Learning, Quality Assurance and Quality Performance Indicators

Enablers

- Clear governance structures
- Clear roles and responsibilities
- Our workforce
- Digital and information
- Research, Innovation and Knowledge
- Annual delivery

Quality and Safety is everyone's business and we all have a role to play in delivering our aim.

We will:

- role model NHS Fife's organisational values to ensure staff always feel confident to report or escalate safety and quality concerns
- review and learn when things go wrong to reduce the chances of future harm
- lead with compassion
- maintain clear governance structures which align to the Whistleblowing Policy and core principles
- ensure that the wellbeing of our workforce is a priority
- ensure that Senior Managers and Leaders are visible and will overtly demonstrate their commitment to quality and safety thereby creating an environment which encourages and empowers staff to contribute
- ensure that good practice is shared, celebrated and learnt from
- ensure that learning is shared widely across the organisation
- adopt a systems approach to learning and continuous quality improvement which engages and is driven by our staff
- Develop a human factors and safety culture approach

We will

- use the risk profile to inform the prioritisation of improvement activities
- ensure clearly defined quality performance indicators that are readily available from "ward to Board" to measure, monitor and evaluate the quality and safety of care and allow early action when we identify a concern
- use multiple sources of data and other intelligence (including external reports such as inspection reports) to identify the need for improvement, provide assurance of quality performance and inform any organisational learning opportunities.
- use feedback and engage with our public to learning from people's care experience to inform change, improvement and assess the quality of assurance provided by our quality systems.
- develop a programme of work will be agreed in collaboration with Internal Audit to provide assurance that the system of internal controls is functioning as intended.
- ensure that a programme of clinical audit helps us identify areas for improvement
- ensure our clinical policies and procedures are reflect current best practice and are easily accessible
- create systems and processes which support effective organisational learning
- learn from adverse events and legal claims

We will:

- Ensure our systems and processes digitally enabled to allow easy and efficient access to information
- Provide training and education to equip staff with the appropriate knowledge and skill to contribute to the delivery of this framework.
- Develop quality improvement capacity across the organisation.
- Establish clearly defined system wide governance structures and processes to provide robust internal assurance supported by clear escalation routes from the point of delivering care to our patients to our Board
- Present a clear vision of responsibility and accountability for clinical governance across NHS Fife including areas delegated to the Integration Joint Board (IJB).
- Develop an annual delivery plan will support the delivery of this framework.
- Ensure that clinical governance meetings are supported by focused agendas, workplans, monitoring of performance and focus on risks.

Clinical Governance Strategic Framework (DRAFT)

Delivering safe, effective, person-centred care in an organisation which listens, learns and improves

2022–2025

Published March 2022

www.nhsfife.org

Contents – [To be updated]

Executive Introduction

"We want to ensure that the care our patients receive is of a standard that we would want for ourselves, our friends, family and loved ones. This framework sets out the fundamental principles that apply to us all every day no matter what role we play in the organisation. Actively listening, learning and improving from the experiences of our staff and patients is at the heart of delivering safe, effective and person centred care. To achieve this aim we must ensure that every day our organisational values are at the heart of the way we treat one another, our patients and our population."

Dr Chris McKenna
Medical Director, NHS Fife

Mrs Janette Owens
Director of Nursing, NHS Fife

1. Purpose

1.1 Our aim is to deliver safe, effective, person-centred care as an organisation which listens, learns and improves. This framework defines the objectives, expected outcomes, activities and measures required to achieve this aim across our healthcare system.

1.2 Our healthcare system is complex and we all have a role to play in delivering high quality care for our patients across their full care pathway and ensure service design is aligned to Realistic Medicine principles.

1.3 At the heart of this framework is people:

- the patients we care for, their families and carers;
- our staff who deliver care; and
- the population of Fife

1.4 Our aim is to empower, support and equip our staff by working as a team, providing the appropriate information and support to deliver excellent care. Underpinning this is the importance of openness and learning to ensure that we are continuously making improvements to the quality of care.

1.5 This framework aligns to NHS Fife's 4 strategic priorities:

Framework Review

1.6 Given the continual changing nature of our healthcare system, this framework will be reviewed on an annual basis with an update provided to the Clinical Governance Committee by March of every year. This will ensure that this fundamental framework remains contemporary and reflects any strategic changes decided by the Board along with changes in national priorities.

1.7 The framework will be fully refreshed and reviewed in 2025.

What is Clinical Governance?

1.8 Clinical governance is defined as “A framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.” (Scally and Donaldson,1998).

1.9 Clinical Governance is a multifaceted concept which requires consideration of the following: alignment to strategy, structures, processes, leadership, roles and responsibilities, and activities underpinned by creating an environment which promotes openness, transparency, listening and learning in line with our organisational values.

1.10 Continually improving quality and safety is a fundamental priority for NHS Fife. The responsibility to deliver effective clinical governance spans our full organisation from the point of care delivery to our Health Board. How we will achieve this is set out in the framework overview (page 6).

1.11 It is important to note that the ambitions of this framework will only be fully realised through the development and delivery of an annual delivery plan. This plan will set out practically how we will achieve our aim every year.

1.12 Some everyday examples of how you might participate in achieving the aim of this framework are set out below:

Info graphic update

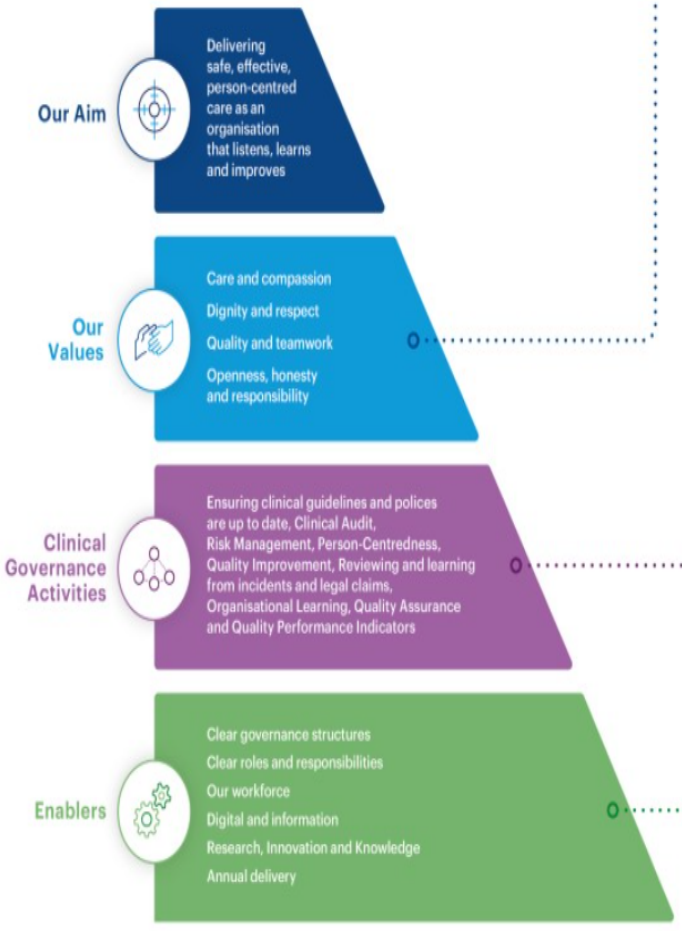
- “ensure people receive evidence based care by supporting audit in your area.”
- “Taking time to listen to patients and their family to understand what matters to them”

Framework overview

Clinical Governance Framework

An enabling framework which aligns to our strategic framework priorities to

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



Quality and Safety is everyone's business and we all have a role to play in delivering our aim.

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- role model NHS Fife's organisational values to ensure staff always feel confident to report or escalate safety and quality concerns
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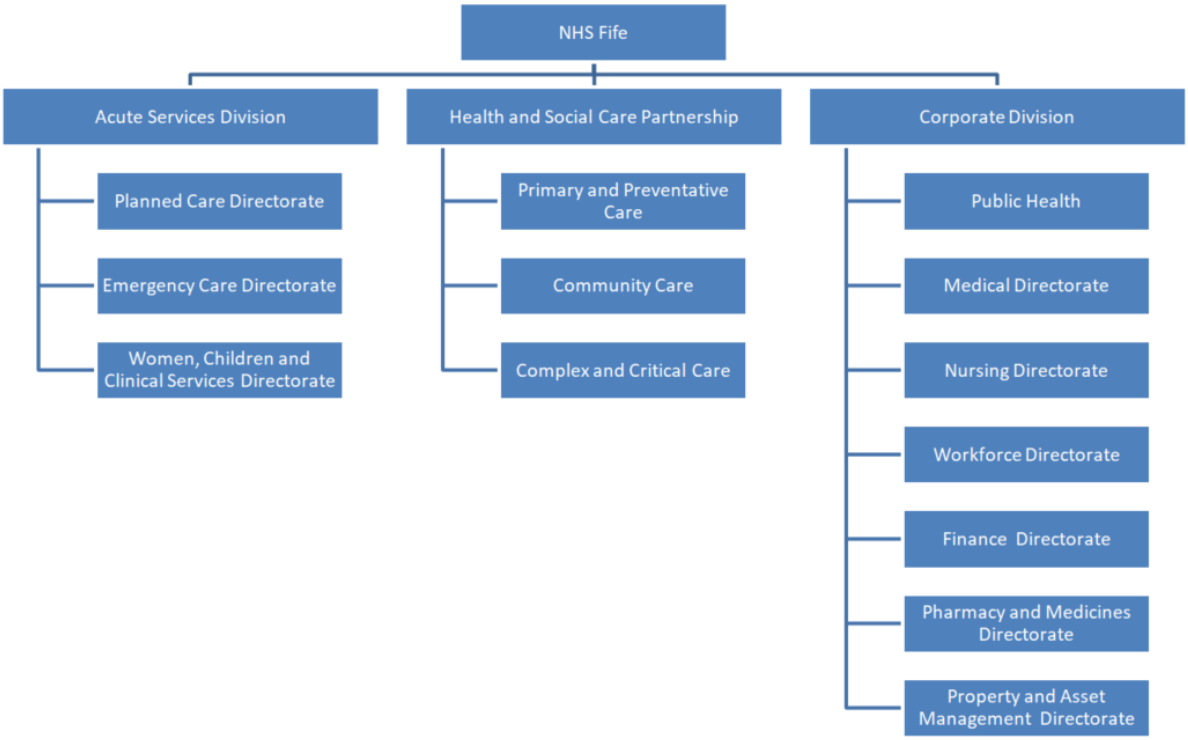
- Develop an annual delivery plan will support the delivery of this framework.
- Ensure that clinical governance meetings are supported by focused agendas, workplans, monitoring of performance and focus on risks.

2. Scope

2.1 This Framework applies to all aspects of health delivery across NHS Fife as shown in the diagram below.



3. Strategic Context

3.1 The diagram below summaries:

- The national documents which influence our approach to clinical governance in providing the historical and contemporary context;
- NHS Fife strategies which this framework and the actions taken to implement must align with; and
- Local policies and procedures which must align to this Framework

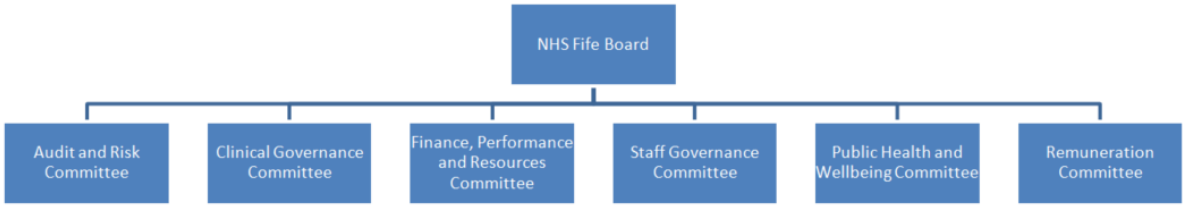
4. Governance structures

4.1 This section sets out the oversight, assurance and monitoring from the point of service delivery to NHS Fife Board.

4.2 NHS Fife Board is responsible for the quality of clinical care delivered in NHS Fife. There are a number of structures below the Board which have delegated responsibility to monitor and assess the clinical governance systems and processes and initiate action and improvements when required.

4.3 The Corporate Governance Structure within NHS Fife includes the NHS Fife Clinical Governance Committee (CGC) (figure 1), a key standing Committee of the Board. This committee has a direct reporting line to the Board.

Figure 1: NHS Fife Governance Structure



4.4 The 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. The role and remit of this Committee is detailed within the NHS Fife Code of Corporate Governance. There are a number of groups which report directly to the NHS Fife CGC. These groups have an overseeing role in the specific area of responsibility on behalf of the NHS Fife CGC (shown in figure 2). The remit of the groups which report into the CGC are summarised in appendix 1.

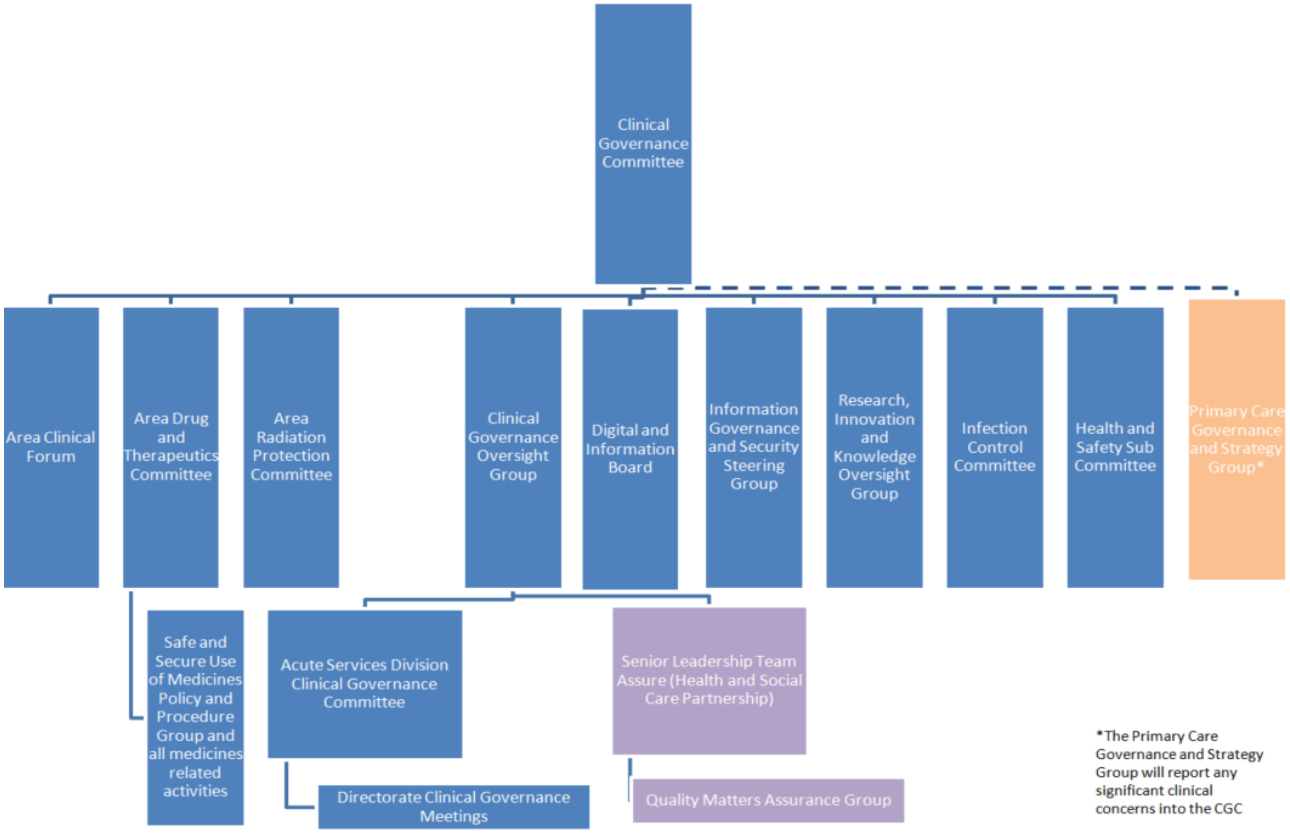
4.5 Operationally, the Executive Directors' Group (EDG) also acts as a point of escalation for clinical-governance related matters as required through the internal management structure.

4.6 The Chief Executive, as Accountable Officer of NHS Fife, and both the Medical Director and Director of Nursing hold various professional responsibilities for ensuring quality, safety and standards of care, as well as efficient and effective use of resources. EDG is the forum for broader discussion and decision-making within the NHS Fife Executive Team, in relation to the delivery of the Board's strategic priorities and key operational, clinical and performance issues, and is a key component in overall assurance reporting to the governance committees and the Board itself.

4.7 The purpose of the CGC and how the framework supports the Committee is summarised below:

	Purpose	How this framework supports delivery
1	To oversee clinical governance mechanisms in NHS Fife	Clinical governance structures are clearly defined within the framework
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	Clinical governance quality performance indicators (QPIs) are clearly defined within the framework and reported on through Integrated Quality and Performance Report (IPQR) and are presented to the Committee for assurance. In addition the CGC workplan is designed to capture all key clinical governance planning and activity with reports scheduled
3	To oversee the clinical governance and risk management activities in relation to the development and delivery of the Clinical Strategy	The Committee has ownership and responsibility for corporate risks aligned to NHS Fife strategic priorities which sit within the remit of the committee
4	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, including health improvement activities	As set out in the framework: • Clarity of governance structures and associated terms of reference • Overview of clinical governance activities and how these support effective escalation and early identification of improvement opportunities
5	To assure the Board that the Clinical and Care Governance Arrangements in the Integration Joint Board (IJB) are working effectively	Captured within the framework delivery plan is a the work underway to redesign the governance structures for the HSCP and IJB
6	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 IJB	Agendas contain items for escalation with concerns flagged as appropriate

Figure 2: Sub Structure of the Clinical Governance Committee

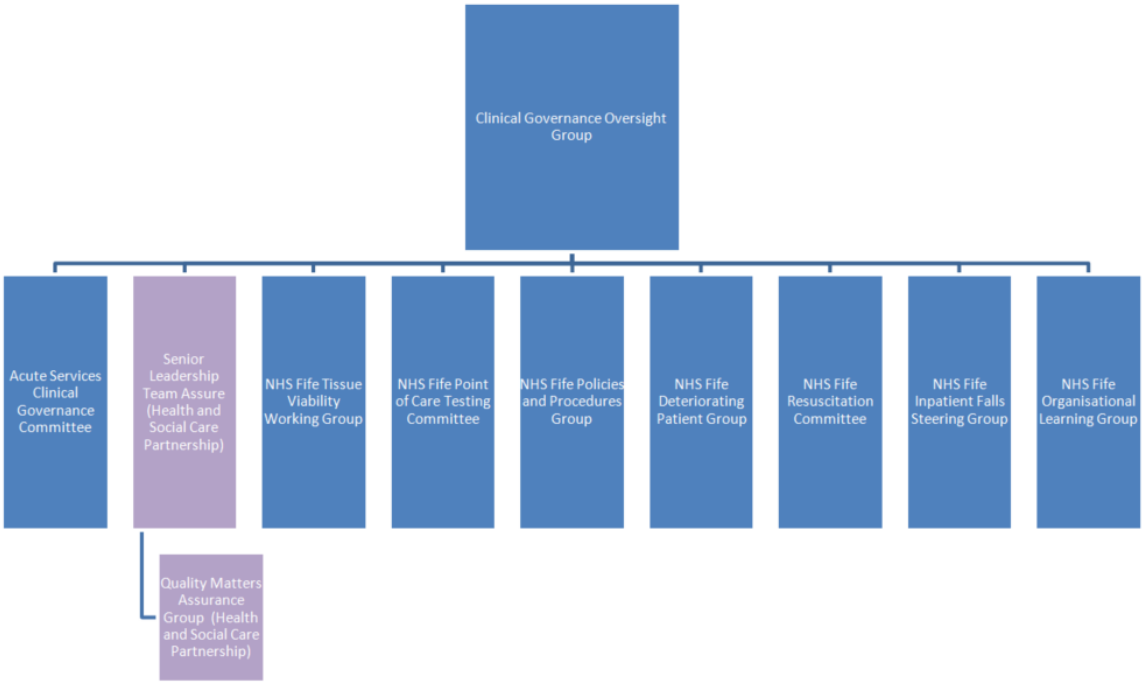


4.8 The Clinical Governance Oversight Group (CGOG) is the group responsible for the operational delivery of this framework. This group has responsibility to take an overview of the quality and safety of care across NHS Fife. The NHS Fife Medical Director chairs this group with members of the group comprising of leadership from across NHS Fife. A number of groups report into the CGOG (Figure 3). The purpose of the group is to use sources of information to provide assurance to the CGC by:

- Identifying issues relating to quality of care; either through escalation or review of information scrutinised by the group
- Reviewing and identify risks with escalation to the CGC as required with the Committee retaining responsibility for aligned corporate risks
- Recommending and influencing organisational improvement activities
- Monitoring outcomes and the actions implemented to improve key clinical governance outcome indicators
- Receives annual organisational Duty of Candour Report in advance of submission to the CGC with responsibility for the oversight of the application of the Duty of Candour Regulations (Scotland) 2018.

4.9 On an annual basis the CGOG will provide an Annual Assurance Report and statement based on the delivery of an agreed workplan.

Figure 3: Clinical Governance Oversight Group Sub-Structure



*Please note that HSCP structures to be confirmed and clarified

4.10 Committee assurance principles (Appendix 2) are applied to the Board and Standing Committees. Effective scrutiny, governance and assurance is achieved through clear focus on strategic direction and agreed outcomes. Practically this is underpinned by having a clear set of priorities and supported by:

- Focused agendas
- Workplans
- Monitoring of performance
- Focus on risks

4.11 Sub-committees and sub-groups of Standing Committees have oversight for operational matters; principles will be applied to ensure robust assurance is provided.

Figure 4 and 5 shows the clinical governance structures within the Acute Services Division, Health and Social Care Partnership and Medicines Directorate (proposed). These structures demonstrate the linkages between operational clinical governance structures and Fife wide clinical governance structures.

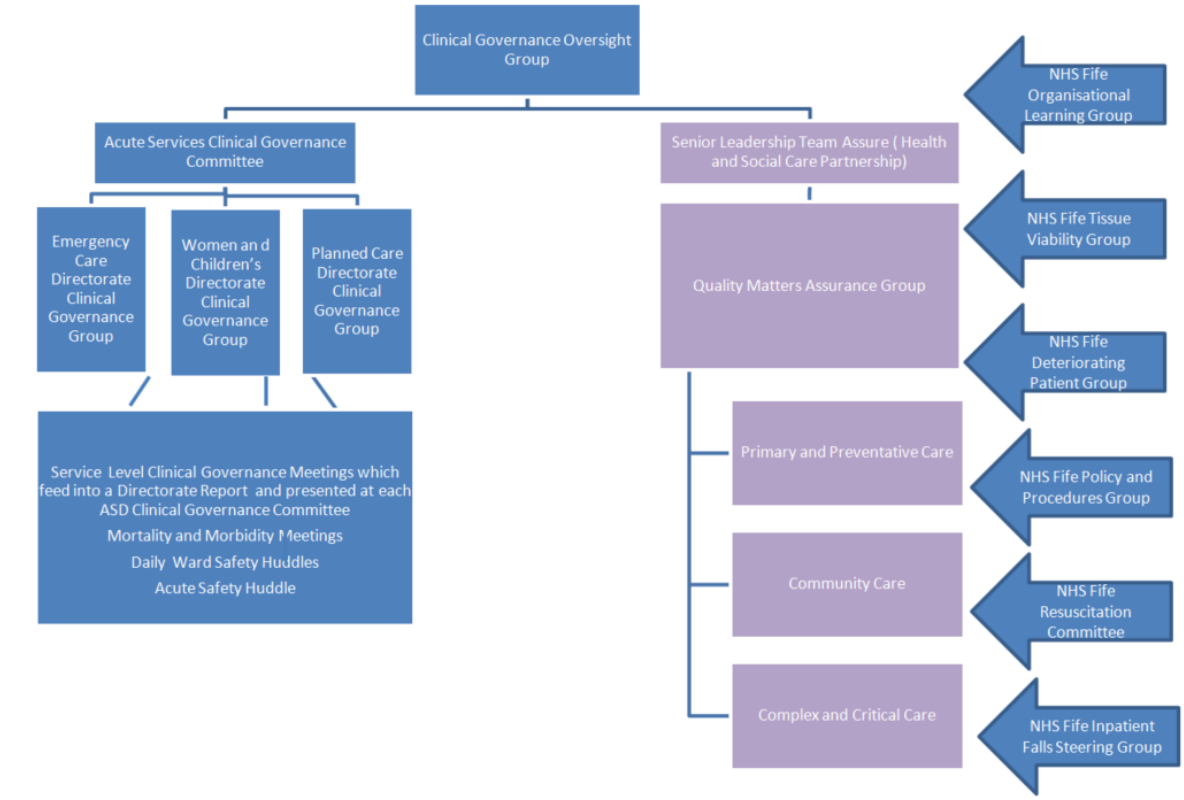
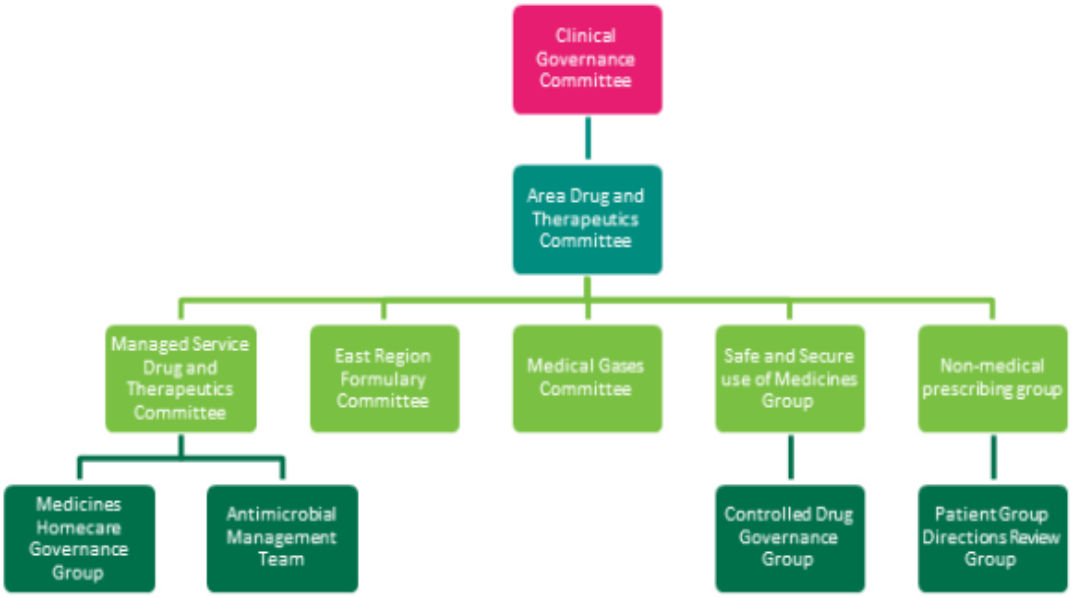


Fig 5. Medicines Governance Structure: Under Review Proposed Core Groups and Structure shown



Integration Framework and Services Delegated to the Integration Joint Board

4.12 To ensure clarity of governance it is important that this framework sets out arrangements for services which are delegated to the Integration Joint Board (IJB). The clinical governance arrangements for delegated services are included in the Fife Health and Social Care Integration Scheme between Fife Council and NHS Fife (clinical governance section appendix 3).

4.13 Ultimate management of operational clinical risks associated with services delegated to the IJB rests with NHS Fife Board and as such systems and processes through the stated governance structure support effective oversight and assurance of these risks.

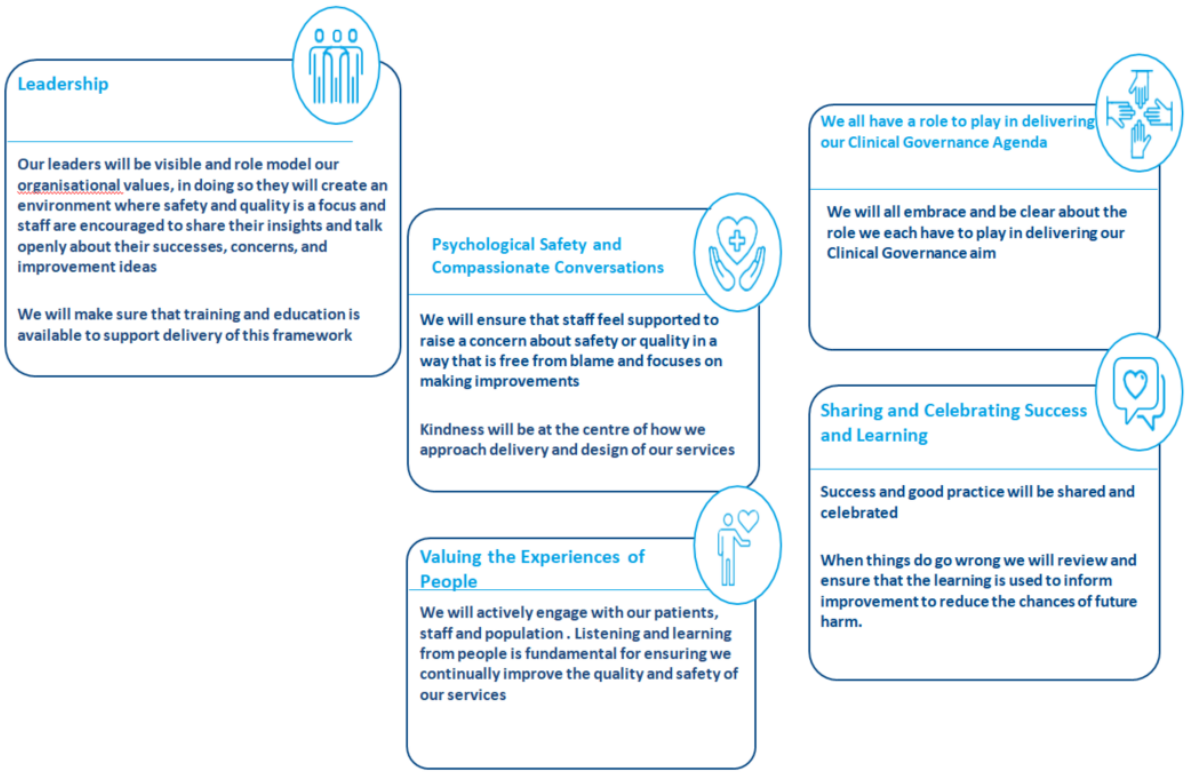
4.14 As stated in section 5.8 of the Integration Scheme the IJB will develop a joint Clinical and Care Governance Framework defining governance arrangements and professional advice for delegated services and at the interface between services.

5. Leadership and Our Values into Action

5.1 We all have a responsibility to role model NHS Fife's Values. This is fundamental to creating a safe and just culture. A safe and just culture is comprised of many things including openness, honesty, fairness and accountability. It requires and encourages the reporting of safety and quality concerns, promotes understanding, learning and improvement. Culture cannot be implemented solely based on policy or procedure; rather, it needs to be consistently fostered over time, and by example, at all levels in the organisation. Ultimately, everyone in the organisation has a role in helping to build and maintain a safe and just culture.

5.2 Our leadership commitments to help deliver this aim are:

[Info graphic to be updated]



Psychological Safety

5.3 Psychological safety plays a role in wellbeing by creating an environment in which change can be embraced. It is about candour and whether we feel able and supported to be direct, take risks, and be willing to admit mistakes. It supports learning from those times care doesn't turn out as expected, allowing space for reflection without the fear of blame. Psychological safety for staff will be built into policy and procedures through development of support for staff following an adverse event. This includes in the immediate aftermath, considering the structure of debriefs, the inclusion of staff in the adverse events reviews, being open honest and transparent, treating staff fairly and recognising the important role they play and in the staff support systems.

Being Empowered to Raise a Safety or Quality Concern

5.4 It is important that all of our staff feel empowered and supported to escalate a safety or quality concern/ issue. This can happen at any level in our organization. The table below sets out some examples of concerns that might be identified and how to escalate these.

Example of a Safety or Quality Concern/ Issue	Example Action and Escalation
Delivering Care to Patients or delivering a service which supports patients care you see risky or unsafe behaviour by a colleague	• You should raise your concern directly with your colleague before escalating the matter immediately to your line manager or supervisor
In a clinical service it is identified that there is an emerging theme of clinical incidents relating to medication errors	• Each incident which has been recorded on Datix is reviewed and investigated • Timely feedback is provided to those who have recorded the incidents • A multiprofessional improvement group is convened to understand the issue and identify appropriate improvement actions • The group monitor and evaluate the impact of improvements • The concern is escalated to the Directorate or Divisional Clinical Governance Group to set out the improvement action agreed

Accountability

5.5 The NHS Fife Executive Leads have delegated responsibility for their respective functions from our Chief Executive. Appendix 4 sets out Executive responsibility and accountability for clinical governance.

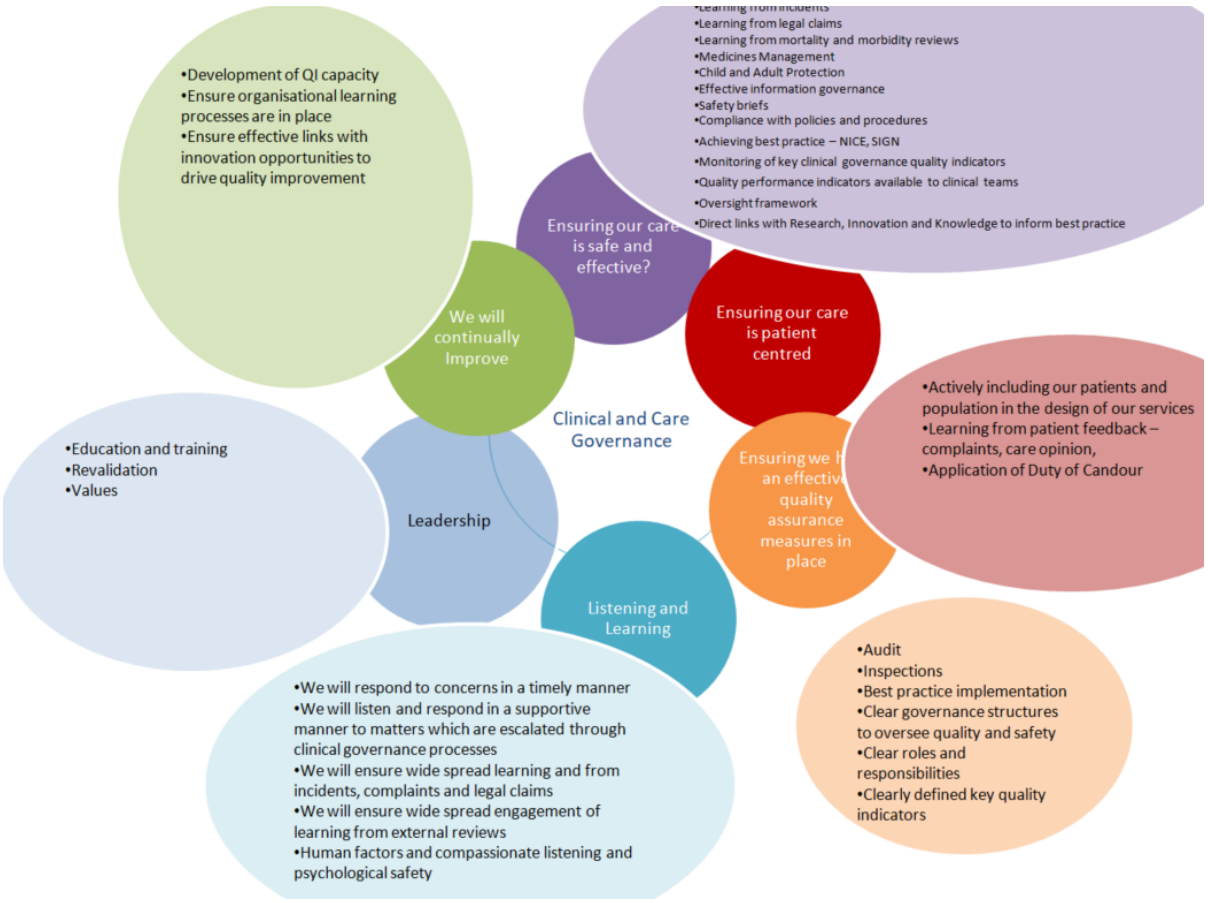
5.6 Independent contractors provide services to NHS Fife. The principles of this framework are applicable to the work delivered by independent contractors. Links are currently by way of their Sub-Committees, the Primary Care Department and the Associate Medical Director, for the Health and Social Care Partnership to the Board Medical Director. Any links with Independent Private Providers is managed through regular meetings and quality reports as part of the Clinical Governance work plan with oversight provided by the Primary Care Strategy and Governance Group.

6. Clinical Governance Activities: Ensuring our care is Safe and Effective

6.1 This section articulates the activities which help to maintain and improve standards of care:

- Reviewing and learning from adverse events
- Effective risk management
- Clinical effectiveness
- Quality Performance Data
- Quality Improvement
- Quality Assurance

[info graphic to be updated]



Using Quality Performance Indicators to Ensure our care is Safe and Effective

- It is important that we have a clearly defined set of quality measures known as quality performance indicators (QPIs) that allow us to monitor and evaluate quality and safety over time. This will ensure that we can take proactive measures to make improvements where required and prevent future harm. This data must be readily available and used at all levels of our organisation from ward to Board.

- QPIs combined with the output adverse events, complaints, legal claims, feedback from inspections, workforce and patient/service user/ public feedback must all be monitored and reviewed to identify any safety or quality concerns. Appendix 5 sets out where these QPIs are reported and reviewed.

- Data and information will be presented in a way that is meaningful and highlights areas of good practice, areas of concern and any associated improvement actions. There will be consistency in how this is presented from clinical areas through governance structures to the Board.

- When we receive feedback from internal or external inspections we will seek to understand why our own systems did not identify areas for improvement. This will be used as a learning opportunity and appropriate improvement implemented

- Our governance structures provide a systematic means to ensure the review of data and to identify areas for action

- Actions taken as a result of assessment of the data will be documented, with any learning shared as appropriate

- The impact of actions taken to improve will be monitored, measured and reported

- There will be an evaluation of the impact reported against key priorities

The table below sets out the key QPIs

QPI	Standard	How the data is used
Major and Extreme Adverse Events	N/A Variation in numbers reviewed	An adverse events is an incident did or could have resulted in harm to a person or to a group of people. The grade and number of adverse events are reviewed on a monthly basis.
Adverse Events Themes	N/A	We need to ensure that we understand trends and themes of clinical incidents so that we can identify improvements to prevent future harm. It is important that we talk openly about incidents and identify good practice as well as areas for improvement
Adverse Events Improvement Actions	70% closure of actions within timescales	It is important that we can demonstrate implementation of improvement actions following an adverse event. Reviewing this data helps to identify where organizational support might be required to help implement a change or improvement.
Duty of Candour	Annual report generated in January reviewing compliance with standards for previous year	The purpose of the duty of candour is to ensure that organisationsare 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 befollowed is set out in the Duty of Candour (Scotland) Regulations 2018.
Hospital Standardised Mortality Ratio (HSMR)	N/A	HSMR provides an adjusted mortality data that takes into consideration existing factors which might affect the risk of death. This data can then be used to make comparisons with other healthcare providers. This data is used locally to monitor mortality rates and to identify improvements to care.
Inpatient Falls	6.91/ 1000 occupied bed days	This data helps to identify proactive response to falls prevention in the hospital setting. There is a national aim to reduce inpatient falls by 20% by 2023. This data is reviewed nationally by the Scottish Patient Safety Programme Adult Falls
Inpatient Falls with Harm	1.65/ 1000 occupied bed days	As above There is a national aim to reduce inpatient falls by 30% by 2023.
Pressure Ulcers	0.89/ 1000 occupied bed days	Pressure ulcers are an unwanted complication of illness, disability or increased frailty. This data is important to ensure that improvement activities can be identified e.g. Education, training, compliance with SKKIN bundle

Staphylococcus Aureus Bacteramia (SAB)	18.8/100,000 occupied bed days	Hospital associated infections are monitored through the Infection Control Committee and reported in the Hospital Associated Infection Report (HARIT).
Clostridium Difficile (C. Diff)	6.5/100,000 occupied bed days	
Escherichia Coli Bacteramias (ECB)	40/100,000 occupied bed days	
Surgical Site Infections	Various standards	
Complaint Closed- Stage 1	80%	Ensuring timely response to concerns raised and ensuring any actions are progressed to address concerns
Complaints Closed- Stage 2	50%	Providing a timely and quality response to concerns that are raised by patients, families and carers
Up to date policies and procedures	95%	Our policies and procedures need to be updated to ensure that they reflect current best practice

6.2 NHS Fife will ensure a focus on making improvements in the quality and use of data to monitor performance. This will enable early identification where improvement is required or provide an opportunity for sharing of good practice. Underpinning this is the importance of staff being empowered and supported.

6.3 National priorities such the Scottish Patient Safety Programme will be included in NHS Fife's approach to delivering this framework.

Reviewing and Learning from Adverse Events

When an adverse event occurs it can have a significant impact on the person and staff involved. It is important that we use these events as an opportunity to learn in order to improve the quality and safety of care across the system and reduce the risk of future harm.

How do I report an adverse event?	Insert AE link
If I am involved in an adverse event where I can I access guidance?	NHS Fife will embrace the adoption of compassionate conversations skills by raising awareness and facilitating staff to attend local and national training on this topic. Insert support link

If I am involved in an adverse event where I can I access guidance?	A core value of NHS Fife is care and compassion. This is reflective not only in the things we do but also in the things we say. There are times, particularly following an adverse event when conversations with patients/families and colleagues may be difficult. Disclosure, expressions of compassion and offering an apology are important elements of communication helping both patients/families and staff involved in adverse events in healing and in restoring trusting relationships. Compassionate communication helps people remain empathetic with each other, even in situations fraught with anger or frustration. It supports navigation of difficult conversations, to speak to others without blaming and to hear personal criticisms without withdrawing or becoming defensive. NHS Fife will embrace the adoption of compassionate conversations skills by raising awareness and facilitating staff to attend local and national training on this topic. Insert Link to accessing support

A Human Factors Approach

The approach Human Factor's is the application of scientific knowledge concerned with understanding and managing the capabilities and limitations of people. It recognises that humans will make mistakes and that we need to design our systems to mitigate the risk of human errors occurring. A human factors approach is important for adverse events as it allows reflection system weaknesses, or in the case of near misses, the strengths, and prevention of future events. The embedding of Human Factors principals to adverse events management in policy and education will strengthen safety culture.

Risk Management

An effective Risk Management Framework will be implemented to ensure proactive management of risks across our organisation from ward to Board.

Objectives	• The safety of patients, staff and others coming into our services is protected. • Risks to the delivery of our organisational objectives- quality, delivery and sustainability of services - are identified and mitigated through proactive action planning • Risk management supports organisational change and service development when considering opportunities and risks to improve services • We will adopt a proactive approach to risk management as an effective mechanism for proactively managing risks through effective action plans • Organisational risk appetite will be agreed and communicated at least annually
Enablers	• Ensure visibility of the organisation's risk profile, to enable effective and informed decision making • Ensure a structured and consistent approach to managing risk from ward to board • The Datix system facilitates the consistent recording, management and escalation of risk, across the organisation • Clear systems and processes will be in place for the escalation or risks • Effective risk management will be used to support decision making, planning and performance arrangements, by providing appropriate information for assurance to the respective management and governance structures The Risk Management Team will: • provide organisational support to ensure effective risk management practice • deliver training, education and development to support staff to fulfil their roles & responsibilities • communicate how risk is managed from ward to board • Risks will be aligned as appropriate to groups & standing committees and will feature on agendas
Our values	• Create a forward looking, proactive culture which improves our ability to avoid or manage existing or emerging risks, minimise shocks, be resilient to unwanted events or crisis, and capitalise on opportunities
How do I escalate a risk?	• Insert risk Management framework
Assurance and strategic oversight	• Executive leadership will be provided by the Director of Finance and Strategy • Standing Committees will be clear about their responsibilities and priorities, have focused agendas and workplans and rigorously monitor their performance in line with Committee Assurance Principles • The Board will set a strong risk management culture; and gain assurance on the risk management approach in accordance with Committee Assurance Principles • The Audit and Risk Committee will support the Board by: Reviewing and advising the Board on the effectiveness of the risk identification, management and reporting processes

How do we know we are delivering effective care?

Clinical Effectiveness ensures that people receive evidence based care which is supported by agreed outcome measures and established programmes of clinical audit. Development of audit programmes will be aligned to areas of national priority and to local priority areas identified through e.g. risk management, adverse events, complaints and legal claims.

Objectives	• We will ensure that our clinical practice is based on current evidence Involvement in local and national clinical audit • Clinical audit will be used to monitor against standards and used to drive improvement opportunities and provide assurance • Clinical audit programmes will be aligned to areas of risk or identified through national guidelines, compliance with best practice and national reports • Research, innovation and knowledge will contribute to the development of new practices and ways of delivering care
Enablers	• Staff will have access to training on audit methodology this will be provided by the Clinical Governance Team • We will ensure that our policies and procedures are up to date and easily accessible to staff • Staff will be supported to ensure they have the knowledge and skill to deliver best practice • Our audit programme will consist of national priorities, key programmes determined by specialities as aligned to the risk profile.
Our values	• We will focus on learning and improvement from clinical audits and ensure that recommendations were relevant are implemented
Assurance and strategic oversight	• Executive Leadership is provided by the Medical Director and Director of Nursing • The outcomes of audits and associated improvement actions will be presented through our Clinical Governance Structures

Clinical Audit Programmes

Audit	Audit Programme	Where is Audit Reported?
Scottish Stroke Care Standards	To improve the care of patients who have suffered a stroke by the use of systematic, comprehensive audit of their management and outcome providing feedback through regular reporting and annual review of performance against national stroke care standards.	Acute Services Division Clinical Governance Committee
Medicines Audit Programme	11 audits have been agreed and the frequency of each determined using an audit risk/ ranking system informed by internal audit planning methodology. Audits include: System Anti Cancer Therapy, Prescribing (Medical and Non-Medical), Pharmacy Controlled Drug Check, Medicines Administration Observational Audit: Controlled Drugs, Medicines Administration Observational Audit: Non-Controlled Drugs, Return and Destruction of Medicines, Movement of Medicines, Medicines Requiring Refrigeration, Medical Gases and Safe Handling & Security of Medicines	NHS Fife Safe and Secure Use of Medicines Policy and Procedure Group
Adult Mental Health Standards	To be updated	
Children and Young People Mental Health Standards	To be updated	
National Neonatal Audit Programme	1 in 8 babies born will be admitted to a neonatal unit. The aim of this audit to improve the standard of care provided to babies. Examples of audit measures considered include: Temperature on admission • Antenatal steroids • Retinopathy of Prematurity (ROP) screening • Mother's milk at discharge • Consultation with parents • Neonatal unit transfers	Women and Children's Directorate Clinical Governance Meeting Acute Services Division Clinical

	• Clinical follow-up at 2 years of age • Bronchopulmonary Dysplasia (BPD) • Recording of blood stream and cerebrospinal fluid cultures • Prevalence of Central Line-associated Bloodstream Infections (CLABSI)	Governance Committee
Deteriorating Patient Audit	Cumulative reports are produced quarterly (based on the financial year) for cardiac arrest, cardiac arrest review outcomes and peri arrest. Data are collected for any resuscitation event commencing in-hospital where an individual (excluding neonates) receives chest compression(s) and/or defibrillation and is attended by the hospital-based cardiac arrest team in response to a 2222 call. All individuals in eligible clinical areas receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 call. NHS Fife is participating in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative which is centred around the deteriorating patient and patient falls. Data collected for SPSP will also be reported in this report. It should be noted that the criteria for SPSP is different from the data collected in the audit as this is based on the National Cardiac Arrest Audit (NCAA). Every cardiac arrest is reviewed by the CPR SBAR Review Group. Decisions are then made as to whether a further investigation into the cardiac arrest is required either at an Emergency Bleep Meeting (EBM) or at a Significant Adverse Event Review (SAER).	Reported to Deteriorating Patient Group and Clinical Governance Oversight Group on a quarterly basis
Falls Audit	Monthly report generated on all falls and falls with harm within NHS Fife.	Inpatient Falls Steering Group
Pressure Ulcer	Monthly report generated on all pressure ulcer incidents within NHS Fife.	Tissue Viability Steering Group

Audit		
National Hub for the Review and Learning from the Deaths of Children and Young People	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 a national data core data set. Within scope are all deaths of babies and children up to their 18th birthday and also to include those up to their 26th birthday if they continue to receive aftercare or continuing care at the time of their death. NHS Fife Review Of Children & Young People Deaths Commissioning Group was established in October 2021. The commissioning groups 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.	Annual Report generated for Clinical Governance Committee

Person Centredness

Clinical governance activities relating to person centredness cover the following domains:

- Learning from people's care experience through complaints, compliments, care opinion or through active patient engagement provides valuable information for improving quality of services delivered and assess our systems of assurance and quality
- Active public participation and engagement to gather value information for improving the quality of care and services delivered
- Volunteering
- Equality and Human Rights

Objectives	• Learning from all forms of Feedback (complaints, Care Opinion, compliments) through identifying key themes and trends. This will provide opportunities for shared learning and the sharing of good practice. • Improving accessibility to processes, open, transparency, barriers – inequalities, barriers in accessing complaints processes and services. • Ensure compliance with Equality Act • Involve the public through Participation and Engagement
Enablers	• The Patient Relations Team will provide training, information, data and oversight. The service will provide organisational support to ensure that the requirements of complaint handling are met, data is accurately and sufficiently recorded and that reporting on complaints key themes and learning outcomes can be used to inform change and to share good practice. The same can be said for Care Opinion and Equality & Human Rights data. • **Public directory** Through Participation and Engagement, public and staff will be involved in shaping service change to ensure healthcare services meet the needs of the individual. • **Equality and human rights** Ensure consideration given to the individual, protected characteristics, EQIA process re meeting legal requirements and engagement • **Volunteering** Working with volunteers to support delivery safe care, enhancing patient experience and care journey
Our values	• We will focus on learning from all forms of feedback to improve the care and services delivered, ensuring a person-centred approach
Assurance and strategic oversight	• Executive leadership is provided by the Director of Nursing

Quality Improvement

Quality improvement is a core activity that needs to be aligned to all of the other clinical governance activities described above to enable a systems approach to quality and safety management.

Objectives	• Continuous quality improvement will be a priority to ensure the best services and outcomes for our patients
Enablers	• We will ensure that staff have access to quality improvement training and education, this will include human factors training • Development of the NHS Fife Quality Network to create a collaborative network of staff trained in quality improvement methodology. The aim of this is to inspire a social movement towards the realisation of quality and improvement as a core part of professionalism for all.
Our Values	We will: • ensure that those involved in delivering care are involved and engaged to lead quality improvement • provide visible and active leadership for improvement • Develop a community of practice by providing a structure where strong relationships can be built which foster discussion, support, advice, activities and learning. The community of practice would become a wider coaching / mentoring resource that works to share knowledge, skills and experience to deliver improvement projects
Assurance and strategic oversight	To be updated

Appendix 1

Responsibility of groups reporting into the Clinical Governance Committee

Name of group	Purpose
Clinical Governance Oversight Group	The Clinical Governance Oversight Group is the group responsible for the operational delivery of this framework. This group has responsibility to take an overview of the quality and safety of care. The NHS Fife Medical Director chairs this group with members of the group comprising of leadership from across NHS Fife. A number of groups report into the Clinical Governance Oversight Group. The purpose of the group is to use sources of information to provide assurance to the Clinical Governance Committee: • Identify issues relating to quality of care; either through escalation or review of information scrutinised by the group • Review and identify risks • Recommend and influence organisational improvement activities • Monitor outcomes and the actions implemented to improve key clinical governance outcome indicators
Acute Services Division Clinical Governance Committee	The Acute Services Division Clinical Governance Committee oversees the delivery of the Clinical Governance agenda within the Division and assures the Acute Services Division Committee and the NHS Fife Clinical Governance Committee about the quality of services provided.
Area Drugs and Therapeutics Committee	This Committee is chaired by the Medical Director and reports to the Clinical Governance Committee and the Executive Directors Group. The Committee provides clinical and professional advice and leadership to NHS Fife Board and the Integration Joint Board to ensure patient-centred, safe, clinically effective and cost-effective medicines use and medicines governance, in all care settings.
Area Clinical Forum	The purpose of the Area Clinical Forum is to ensure that efficient and effective systems are in place which promotes the active involvement of all clinicians from across NHS Fife in the decision-making process. The Area Clinical Forum supports the work of Fife NHS Board; and specifically part of the remit is to take forward particular issues on which clinical input is required on behalf of the Board, taking into account the evidence base, best practice, clinical governance and make proposals for their resolution.
Area Radiation Protection Committee	The purpose of the committee is to provide an overview of the management of radiation protection in NHS Fife. The Committee will be concerned with radiation protection requirements for all uses of ionising and non-ionising radiations within NHS Fife and for potential exposures to staff or patients from other sources of ionising radiations.

Name of group	Purpose
Health and Safety Sub Committee	This sub-committee purpose is to ensure that NHS Fife Board provide a safe and secure environment for patients, members of the public, and staff whilst fulfilling all statutory obligations. This sub-committee reports to the Clinical Governance Committee and reports on an exception basis on any particular issues.
Quality Matters Assurance Group	TO BE UPDATED
Digital and Information Board	This Board is chaired by the Executive Lead for Digital and Information and reports to the NHS Fife Clinical Governance Committee. A separate Annual Report and Strategy with detailed objectives for Digital and information are reported to the Committee
Information Governance and Security Steering Group (IG&S)	This Group is chaired by the Executive Lead for Information Governance and Security and reports to the NHS Fife Clinical Governance Committee. It is responsible for overseeing the Information Governance agenda. It is the key purpose of the IG&S Group to act as a Steering Group providing, whole system leadership, oversight and assurance to the organisation and will ensure that all IG&S risks have effective and appropriate mitigations. Accountable to the Clinical Governance Committee but also provide assurance reporting to relevant governance committees as appropriate.
Research, Innovation and Knowledge Oversight Group	This Group is chaired by the Executive Lead for Research, Innovation and Knowledge and oversees this agenda within NHS Fife. It reports to the NHS Fife Clinical Governance Committee. A separate Annual Report and Strategy with detailed objectives for Research, Innovation and Knowledge is available. The purpose of the Research, Innovation and Knowledge Oversight Group (RIK-OvG) is to: • Oversee, monitor and advise on the development and delivery of the NHS Fife RIK Strategy, which will be supported by an annual delivery plan • Oversee and monitor RIK performance targets (including; number of clinical research studies, number of participants recruited, commercial and non-commercial income, number of users of RIK services) • Assure the Clinical Governance Committee, via the Executive Directors Group, that appropriate governance mechanisms and structures are in place for RIK services • Escalate any issues to the Clinical Governance Committee, via the Executive Directors Group, where concerns are identified

Name of group	Purpose
Infection Control Committee	This Committee is chaired by the NHS Fife Executive Lead for Infection Control and reports to the NHS Fife Clinical Governance Committee. This Committee is responsible for overseeing the Infection Control agenda and quarterly and annual reports are produced.

Appendix 2

Committee assurance principles

Purpose and remit

The overall purpose of the Board is to ensure efficient, effective and accountable governance, to provide strategic leadership and direction, and to focus on agreed outcomes. Detailed scrutiny should take place at committee level, with each committee providing assurance and escalating key issues as required. For this to be achieved successfully, Standing Committees must be clear about their priorities, have focused agendas and workplans and must monitor their own performance rigorously. Standing Committee remits are approved by the Board with input from Committees and increasingly from national governance initiatives. However, Standing Committees must ensure that they are focused on Board priorities and on the risks delegated to them.

Sub-committees and groups will frequently have an operational focus but must ensure that they are in a position to provide the required assurances on their operations and on any risks, actions and controls for which they are responsible.

Board or standing committee agenda

In general, for an item to be included on the agenda it should meet the following criteria unless the Committee Chair and Lead Officer agree there are good reasons for its inclusion:

a) It is a decision delegated to that Committee
b) It relates to and/or provides assurance upon a risk delegated to that Committee. In this context, performance reports etc should be overtly related to the specific risk and should contain a conclusion on whether the performance reports indicate that controls are operating effectively to mitigate the risk as intended
c) It is a statutory or regulatory requirement or required by SG guidance
d) The Committee can add value to a decision or issue by providing a different perspective, setting boundaries or generating ideas.

Assurance

At the start of the year, the Committee should consider its remit and determine its assurance requirements together with how these will be met, using assurance mapping principles. This should be set out in the Committee assurance plan or clearly identified within the Committee work plan. The 'three lines of assurance' are often used to help categorise assurances

- First line: management assurance from "front line" or business operational areas;
- Second line: oversight of management activity, including effective management information, separate from those responsible for delivery, but not independent of the organisation's management chain;
- Third line: independent and more objective assurance, including the role of Internal Audit and from external bodies

Assurances should be:

a) Overtly linked to the relevant risk with an overt conclusion from the responsible director or officer
b) Streamlined so that there is no omission, no unnecessary duplication
c) Relevant: data should not be presented just because it is readily available
d) Reliable: assurances should be evaluated so that it is clear how much weight should be placed on any piece of evidence and how they fit in with other relevant evidence
e) Sufficient: there should be sufficient evidence in total to allow a reasonable conclusion to be reached

The Board has delegated responsibility for most strategic risks to Standing Committees. Following a discussion of an agenda item, the committee should formally assess the level of assurance received. This is reported to the Board via the Chair's assurance report (see below). The following criteria (based on work undertaken by the Good Governance Institute) can help in assessing the level of assurance:

a) Independent assurance (such as an auditor's opinion) carries more weight than internal evidence produced by management
b) The best assurance is commissioned specifically to assure that a control is effective: reams of evidence with only indirect relevance does not provide good assurance
c) Assurances are time-limited and should only be relied upon if current
d) Differentiate between positive, negative and neutral opinion when using independent assurance
e) Ensure that assurance is consistent: triangulate different sources and use independent evidence to assess the accuracy of internal assurance sources

Appendix A provides examples of questions that Committees and groups should ask about risks.

Chair's report/Assurance Report

Minutes are valuable for the group itself but are not normally an efficient and effective source of assurance. An assurance report allows issues to be collated and presented in a way that gives readers a quick and comprehensive summary of the key issues, without considering unnecessary detail or having to decode or investigate areas of interest.
The following questions should be considered at the end of every Standing Committee and sub-group meeting and areas for recording agreed. These should then be included in the Chair's summary/assurance report and taken forward by the Responsible Director:

f) Are there any issues which could be a disclosure in the Governance Statement (see below) or should be included within the Committee year-end report
g) Are there any new risks emerging which require escalation to the Board or recording in the Strategic or operational risk registers
h) Is the Committee fulfilling its workplan and if not, would any omissions have an impact on its ability to provide assurance at year-end
i) For the risks delegated to the Committee:
    - Are the scores correct?
    - Have there been any significant movements?
    - Has the committee received assurances that internal controls intended to mitigate the risk are working as intended and are effective?
    - Does performance reporting support this?
    - Has the committee received assurances that actions intended to reduce the risk to its target level are working as intended and will be effective?

Year-end reports

At the end of the financial year, Standing Committees provide their annual report to the A&RC (and Board). Standing Committee annual reports are an opportunity to reflect on the year just gone and should be used to consider overall progress and key issues going forward. The annual report should be focused on the most important issues and should include, as a minimum:

a) A clear description of movement in strategic risks aligned to the committee and areas where actions were not effective
b) Overt identification of areas of non-compliance and explanation of the impact on the control environment
c) Clear performance information and highlighting of areas of poor performance
d) Inclusion of Key Performance Indicators where possible
e) Rather than stating that a report was presented, providing a broad conclusion on whether the level of assurance provided was acceptable (noting that the new process for assessing assurance will aid this recommendation)
f) Any specific requirements for that Committee based on its remit or duties such as an overt opinion by the SGC on whistle-blowing arrangements based on an appropriate annual report or the P&RC opinion on whether value for money was achieved

g) Consideration of key risks and concerns and how these will be reflected in the workplan for the year ahead.

The Audit and Risk Committee must decide whether an item is of sufficient significance to be included in the narrative of, or disclosed within, the Governance statement. By extension Standing Committees should consider, whether an item should be brought to the attention of the Audit Committee within their annual report/assurance statement.
Useful considerations in deciding whether an item should be disclosed include:

a) Is it material? The HIS risk management 'impact' criteria provide a helpful guide
b) Does it represent a control weakness? Some issues could not reasonably have been prevented
c) Was the control weakness in place in the year in question? A weakness in place throughout most of the year should be mentioned, even if resolved after or at year-end. However, if the issue was discovered in year but related to a weakness in previous years now rectified then it need not be disclosed

Appendix A - Assessing risks

Questions for risk owners:

- Would you know if your controls are working effectively as intended or failing?
- Can you evidence the effectiveness of the controls?
- Can you assure your Governance Committee of the effectiveness of controls?
- Do you have assurance for all three lines of defence?
    - 1st line - management / performance / data trends
    - 2nd line – oversight / compliance / audits
    - 3rd line – internal audit and/or external audit reports / external assessments
- If Yes - why above appetite?
- If No – How are the mitigating controls reflecting improvement or is there an action plan?
- Do you understand both the criticality and effectiveness of controls
    - Criticality: How important to the mitigation of the risk? The higher the importance of the control in mitigating the risk, the more assurance is required. If the control is of low importance is it a valid control to attach resource / effort
    - Effectiveness: This should measure if the controls are well designed / appropriate as well as how effectively they are implemented

Risk Questions for Committees

General questions:

- Does the risk description include all known material factors and adequately 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 adequate i.e. well-designed and effective i.e. implemented properly
- Will further actions bring risk down to the planned 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 overtly link to the BAF/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 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
    - Ensuring there is clarity over what the listed controls etc. actually do e.g. if there is a group, what is it for (noting a group might be all three or actually none)?
- 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 is given or can be concluded and how does this compare to the required level of assurance (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

Appendix 3

Integration Framework and Services Delegated to the Integration Joint Board, July 2021

Section 5 of the Fife Health and Social Care Integration Scheme between Fife Council and NHS Fife (March 2022) clearly defines the clinical governance arrangements for delegated services:

The arrangements for clinical and care governance agreed by the Parties are:

5.1 The Executive Medical Director, Director of Public Health and Executive Nurse Director, NHS Fife are accountable to the NHS Fife Clinical Governance Committee for quality of care delivery and professional governance in relation to the delegated NHS Fife functions.

5.2 The Chief Social Work Officer, Fife Council is accountable for ensuring proper standards and values are maintained in respect of the delivery of Social Work Services delegated to this Integration Joint Board. The Chief Social Work Officer provides specific reports including the annual report and assurance to the relevant committee of Fife Council.

5.3 The Chief Officer as Director of Health and Social Care has delegated operational responsibility for integrated services. The Chief Officer, Medical Director, Nurse Director, Director of Public Health and Chief Social Work Officer will work together to ensure appropriate standards and leadership to assure quality including at transitions of care.

5.4 The Parties will continue to monitor and report on clinical, care and professional governance matters to comply with legislative and policy requirements.
5.5 The Executive Medical Director, the Director of Public Health and the Executive Nurse Director continue to attend the NHS Fife Clinical Governance Committee which oversees the clinical governance arrangements of all NHS Fife service delivery divisions.

5.6 Professional oversight, advice and accountability in respect of care and clinical governance are provided throughout the Partnership by the Executive Medical Director Executive Nurse Director, and Professional Lead Social Worker.

5.7 Professional advice is provided to this Integration Joint Board through named professional advisors in line with section 12 of the Act. Advice is also provided through the Strategic Planning Group, Localities and an Integrated Professional Advisory Group comprising of health and social care professionals. The existing advisory groups will be linked to the Integrated Professional Advisory Group and will provide advice, as required, and be fully involved in Strategic Planning processes.

5.8 Assurance will be given through arrangements which will come together in an integrated way. The IJB will agree a clinical and care governance framework setting out efficient and effective arrangements for clinical and care

governance, supported by the appropriate professional advice, covering all delegated services and at the interface between services. This framework will be developed in partnership with both Parties and the arrangements will clearly set out assurances to the IJB and its partners as well as those for the escalation and resolution of clinical and care risks.

5.9 The Parties will ensure clinical and/or care governance arrangements are congruent with those of the IJB. Any changes to these arrangements will be agreed between the Parties and implemented through a minute of variation signed on behalf of both Parties and the IJB.

5.10 This Integration Joint Board will, through the Chief Officer, establish a framework and mechanisms as appropriate to receive assurance on the systems in place to discharge their statutory responsibilities for the requirements of the Act. This relates to the delivery of integrated health and social care arrangements including the Principles of Integration (Section 4), Health and Wellbeing Outcomes (Section 5), the Quality Aspects of Integrated Functions for Strategic Planning and Public Involvement (Sections 29-39), delivery of Integration through Localities, Directions and the Annual Performance Report (Sections 40-43).

5.11 The Strategic Planning Group has medical, nursing, social work, Allied Health Professionals and other key stakeholders and professional staff in its membership to ensure appropriate advice is provided throughout the process of strategy development, implementation and review.

Appendix 4

Executive Director Clinical Governance Responsibilities

NHS Fife Chief Executive

The Chief Executive has a responsibility for the organisation as a whole. In particular the Chief Executive has a responsibility for the quality of all clinical services provided within NHS Fife.

NHS Fife Medical Director

The Medical Director is the identified Executive responsible for leading the development and implementation of the Clinical Governance systems, including Clinical Effectiveness, within the organisation. The Medical Director as Caldicott Guardian is responsible for ensuring that NHS Fife complies with the guidance in the Caldicott Reports and for the development of Clinical Governance within Public Health.

Director of Nursing

The Director of Nursing is the Executive Lead as well as for participation and engagement, and Infection control.

Director of Finance and Strategy

The Director of Finance and Strategy is the executive lead for risk management

Director of Health and Social Care

The Director of Health and Social Care is the Chief Officer for Health and Social Care to the Integration Joint Board. In particular this officer reports to the Chief Executive of Fife Council, and the Chief Executive of NHS Fife, and has responsibility to ensure the partnership reports clinical and care governance performance to the IJB Clinical and Care Governance Committee and the NHS Fife Clinical Governance Committee when appropriate.

Director of Pharmacy and Medicines

The Director of Pharmacy and Medicines is the Executive lead for pharmaceutical care and medicines governance within the organsiation. This ensures that pharmaceutical care servies and multidsiplinary systems function to assure the safe and effective use of medicines in NHS Fife. The Director of Pharmacy and Medicines also serves as the Board's Controlled Drugs Accountable Officer.

Appendix 5

QPIs where these are reviewed and reported – TABLE being updated key to be added

		Where data is reported and reviewed			
QPI	Standard	Service	Directorate	Divisional	Fife Wide- Organisational
Major and Extreme Adverse Events: Numbers Themes Compliance with 90/ 60 day standard	N/A	Service	ASD Directorate Meetings	SLTA QMAG QMASH ASD CGG	IPQR CGOG OLG
Adverse Events Themes	N/A			SLTA QMAG QMASH ASD CGG	IPQR CGOG OLG
Adverse Events Improvement Actions	70% closure of actions within timescales			SLTA QMAG QMASH ASD CGG	IPQR CGOG OLG
Duty of Candour	Annual report generated reviewing compliance with standards			ASD CGC	CGOG CGC
Medication Incidents	N/A			SUMMP Group	ADTC

Cardiac Arrest	N/A				DPG CGOG EBM EBG
Hospital Standardised Mortality Ratio (HSMR)	N/A				IPQR CGC CGOG
Inpatient Falls	6.91/ 1000 occupied bed days	IPQR			Inpatient Falls Steering Group
Inpatient Falls with Harm	1.65/ 1000 occupied bed days	IPQR			Inpatient Falls Steering Group
Pressure Ulcers	0.89/ 1000occupied bed days	IPQR			Tissue Viability Group
Staphylococcus Aureus Bacteramia (SAB)	18.8/ 100000 occupied bed days	IPQR			IPCC
Clostridium Difficile (C. Diff)	6.5 / 100000 occupied bed days	IPQR			
Complaint Closed- Stage 1	80%	IPQR			
Complaints Closed- Stage 2	50%	IPQR			
Up to date policies and procedures		NHS Fife Policy and Procedure			NHS Fife Policy and Procedure Group Clinical Governance

		Group Clinical Governance Oversight Group			Oversight Group

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

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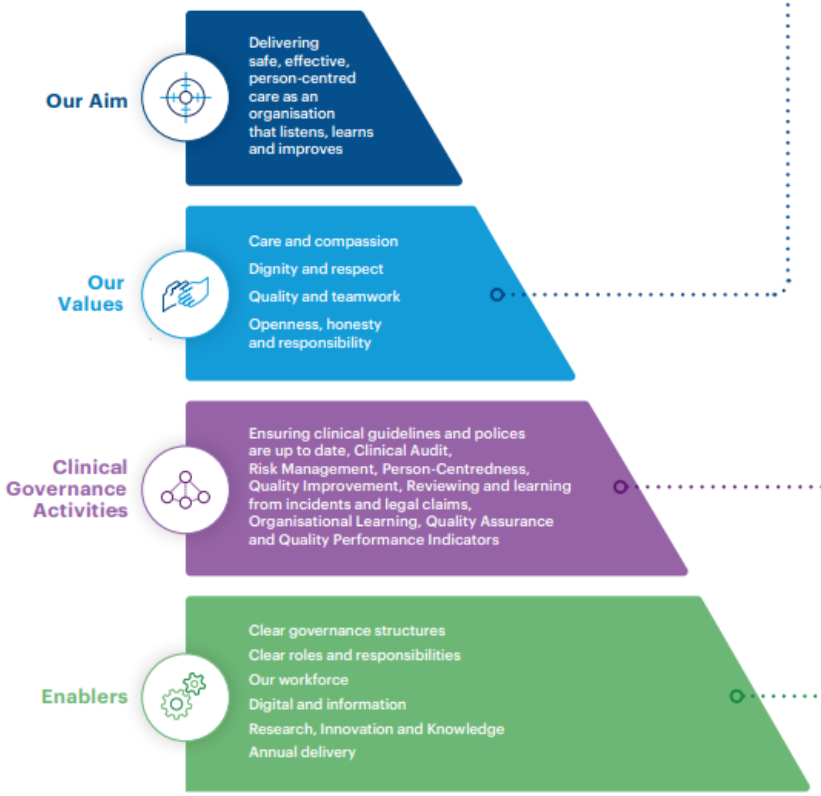
NHS Fife

Clinical Governance Framework

An enabling framework which aligns to our strategic framework priorities to

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



Quality and Safety is everyone's business and we all have a role to play in delivering our aim.

We will:

- role model NHS Fife's organisational values to ensure staff always feel confident to report or escalate safety and quality concerns
- review and learn when things go wrong to reduce the chances of future harm
- lead with compassion
- maintain clear governance structures which align to the Whistleblowing Policy and core principles
- ensure that the wellbeing of our workforce is a priority
- ensure that Senior Managers and Leaders are visible and will overtly demonstrate their commitment to quality and safety thereby creating an environment which encourages and empowers staff to contribute
- ensure that good practice is shared, celebrated and learnt from
- ensure that learning is shared widely across the organisation
- adopt a systems approach to learning and continuous quality improvement which engages and is driven by our staff
- Develop a human factors and safety culture approach

We will

- use the risk profile to inform the prioritisation of improvement activities
- ensure clearly defined quality performance indicators that are readily available from "ward to Board" to measure, monitor and evaluate the quality and safety of care and allow early action when we identify a concern
- use multiple sources of data and other intelligence (including external reports such as inspection reports) to identify the need for improvement, provide assurance of quality performance and inform any organisational learning opportunities.
- use feedback and engage with our public to learning from people's care experience to inform change, improvement and assess the quality of assurance provided by our quality systems.
- develop a programme of work will be agreed in collaboration with Internal Audit to provide assurance that the system of internal controls is functioning as intended.
- ensure that a programme of clinical audit helps us identify areas for improvement
- ensure our clinical policies and procedures are reflect current best practice and are easily accessible
- create systems and processes which support effective organisational learning
- learn from adverse events and legal claims

We will:

- Ensure our systems and processes digitally enabled to allow easy and efficient access to information
- Provide training and education to equip staff with the appropriate knowledge and skill to contribute to the delivery of this framework.
- Develop quality improvement capacity across the organisation.
- Establish clearly defined system wide governance structures and processes to provide robust internal assurance supported by clear escalation routes from the point of delivering care to our patients to our Board
- Present a clear vision of responsibility and accountability for clinical governance across NHS Fife including areas delegated to the Integration Joint Board (IJB).
- Develop an annual delivery plan will support the delivery of this framework.
- Ensure that clinical governance meetings are supported by focused agendas, workplans, monitoring of performance and focus on risks.

1.1 The principles and intentions set out in the Clinical Governance Framework will only be fully realized through the support of an annual delivery plan.

1.2 Assurance and oversight of the delivery plan will be provided through the Clinical Governance Oversight Group supported by a midyear and end of year report to the Clinical Governance Committee. Any matters that require escalation will be escalated to these groups as appropriate.

1.3 The annual delivery plan for 2022/2023 is set out below:

		Workstream	Description/ Objectives	Lead(s)	Timescale	Status
Our Values	1.1	Organisational Learning	Embed the Organisational Learning Group Identify opportunity for organisational thematic learning (along with facilitating action to support improvement) and develop a means for sharing learning from clinical events and good practice more widely across the organisation	Associate Director for Quality and Clinical Governance (Q&CG) and Associate Director for Nursing (Corporate)	Mar 2023	Delivered Group established April 2022
	1.2	Safety and Just Culture	Work with Workforce Directorate to develop a programme of work to ensure that staff are supported to engage in safe, open and transparent way with clinical governance activities Roll out of trauma informed workforce	Lead for Adverse Events	Mar 2023	On Track
	1.3	Patient Representation on the Clinical Governance Committee	Recruit a Patient Representative on the Clinical Governance Committee to ensure that we are valuing and making a connection between the oversight of quality and safety with the direct experiences of our patients Recruit member of public to join the Clinical Governance Committee	Associate Director for Quality and Clinical Governance	Mar 2023	Work required
	1.4	A focus on quality and safety	Work with clinical teams to co-produce a refreshed approach to safety and quality visits	Director of Nursing Medical Director Associate Director for Q&CG	Mar 2023	Work required
Clinical Governance Activities	2.1	Organizational learning communication QI project	Scope programme of work in collaboration with realistic medicine to develop quality improvement actions to address the theme of patient communication identified in patient complaints and adverse events	Associate Director of Nursing for Corporate and Associate Director for Q&CG	Feb 2023	On track
	2.2	Risk Management Framework	Programme of work to refresh the Risk Management Framework including: Clearly defined strategic risks	Director of Finance and Strategic Planning, Risk Manager and	Mar 2023	On track

			Development of a corporate risk register Reviewed escalation processes Development of a risk dashboard Establishing a Risk and Opportunity Group	Associate Director for CG and Q		
	2.3	Scottish Patient Safety Programme	Participation in SPSP Adult Acute Collaborative	Clinical Effectiveness Manager	Ongoing	Ongoing
	2.4	Medicines Safety Programmes	Ensure NHS Fife has a programme of continued improvement with medications safety, including learning from incidents, education improvements, ensuring safe and effective prescribing	Director of Pharmacy	2023/2024	TBC
	2.5	Excellent in Care	Development of Care Assurance Framework for NHS Fife	Director of Nursing	TBC	TBC
	2.6	Quality Network	Collaborate with the Planning and Performance team to contribute to the shape of the quality network particularly in respect of the Organisational Learning Group	Associate Director of Q&CG	TBC	TBC
	2.7	Review of Adverse Events Policy and Procedure	Full review of Adverse Events Policy and Procedure to deliver: Updated training and education Revised process Increase capacity to support adverse reviews Increased focus on improvement plans and learning Staff support Policy update Procedural update	Lead for Adverse Events	 Mar 23 Jun 23	On track
Enablers	3.1	Review of Clinical Governance Oversight Group	Clinical Governance Oversight Group and Adverse Event (AE) & Duty of Candour (DoC) Group to amalgamate to provide overall picture of AE/DoC in the context of the wider clinical governance picture Development of workplan for the group		Apr 22	Delivered
	3.2	Review of HSCP clinical governance structures	Review and embed new clinical and care governance structures including services delegated to the IJB			TBC
	3.3	Review of core quality data and development of Quality Reports	Development of quality report for Acute Services division to ensure clinical governance key quality indicator data is readily available at Divisional, Directorate, Service and Ward levels.	Associate Director of Q and CG and Associate Nurse Director for ASD	May 22	Delivered
	3.4	Upgrade to Datix	Develop business case for Datix Cloud IQ providing improved functionality	Associate Director of	Mar 23	Paused

		Cloud IQ	for clinical governance activities such as Morbidity and Mortality meetings	Q and CG		due to national tender discussion
	3.5	Embed our systems and processes for the reviews of deaths of children and young people	Embed the required infrastructure for the delivery of the national guidance and embed local processes	Lead for Adverse Events	Sept 22	Delivered
	3.6	Development of a Quality Management System (QMS) for NHS Fife	Develop business case in partnership with Digital and Information for a QMS for NHS Fife which enables NHS Fife to achieve its quality objectives whilst enabling patient focussed quality monitoring and process improvements. The solution should enable a controlled and formalised record of relevant documentation including policies, processes, procedures and responsibilities. The solution should facilitate the key activities (Quality planning, assurance, control & improvement) required to meet quality objectives and regulatory requirements.	Associate Director for Q and CG	Apr 24	Requires work – scoping exercise complete
	3.7	NEWS2	Work in partnership with Digital and Information to deliver NEWS2 to deliver benefits to the Deteriorating Patient work including	Associate Director for Q and CG, Head of Programmes for D&I	Dec 23	Requires work- Business Case and being finalised for EDG submission

Describing the HSCP Assurance Arrangements Including Clinical and Care Governance

This document describes the arrangements in place within the HSCP which aims to assure that there are the correct connections and reporting into the appropriate structures of NHS Fife, Fife Council and IJB.

How is Clinical and Care Governance supported by the Integration Scheme?

Legal Position

Public Bodies (Joint Working) (Scotland) Act 2014 define National Health and Wellbeing Outcomes Integration Planning and Delivery Principles with statutory responsibilities clinical and care governance. This is a required section within the Integration Scheme which is a legal document setting out the arrangements adopted by NHS Fife and Fife Council as required by Section 7 of the Act. The full act and what is defined regarding to clinical and Care governance can be read via this link Microsoft Word - Fife Integration Scheme_FINAL_19.08.15 (fifehealthandsocialcare.org)

In Summary in relation to Clinical and Care Governance the Integration Scheme defines

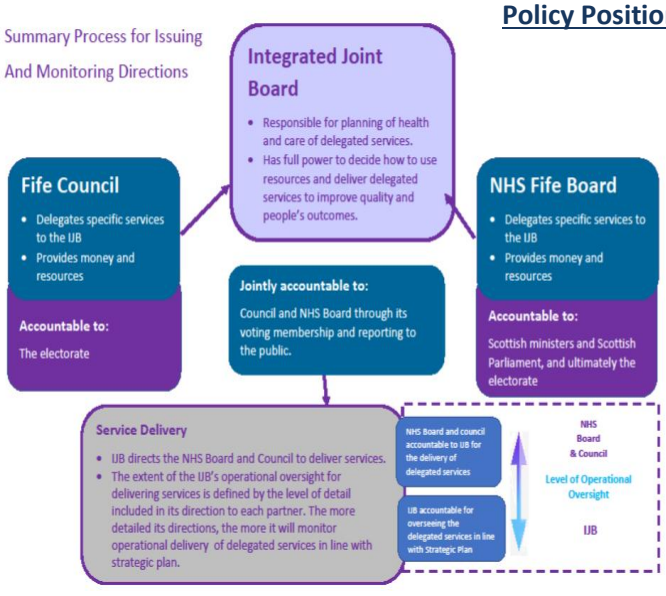
- The Roles of Executive Medical Director, Director of Public Health and Executive Nurse Director, including role for professional oversight and accountability to the NHS Fife Clinical Governance Committee for quality of care delivery in relation to the delegated NHS Fife functions and the accountability of the Chief Social Work Officer to Fife Council in respect of standards and value for social work and social care.
- There is a requirement for Parties (NHS Fife & Fife Council) to monitor and report on clinical, care and professional governance matters to comply with legislative and policy requirements.
- The Chief Officer as Director of Health and Social Care has delegated operational responsibility for integrated services. The Chief Officer, Medical Director, Nurse Director, Director of Public Health and Chief Social Work Officer will work together to ensure appropriate standards and leadership to assure quality including at transitions of care.
- The Integration Joint Board will, through the Chief Officer, establish a framework and mechanisms as appropriate to receive assurance on the systems in place to discharge their statutory responsibilities for the requirements of the Act. This relates to the delivery of integrated health and social care arrangements including the Principles of Integration (Section 4), Health and Wellbeing Outcomes (Section 5), the Quality Aspects of Integrated Functions for Strategic Planning and Public Involvement (Sections 29-39), delivery of Integration through Localities, Directions and the Annual Performance Report (Sections 40-43). Assurance will be given through arrangements which will come together in an integrated way. The IJB will agree a clinical and care governance framework setting out efficient and effective arrangements for clinical and care governance, supported by the appropriate professional advice, covering all delegated services and at the interface between services. This framework will be developed in partnership with both Parties and the arrangements will clearly set out assurances to the IJB and its partners as well as those for the escalation and resolution of clinical and care risks.
- Professional advice is provided to this Integration Joint Board through named professional advisors in line with section 12 of the Act. Advice is also provided through the Strategic Planning Group, Localities and an Integrated Professional Advisory Group comprising of health and social care professionals. The Strategic Planning Group has medical, nursing, social work, Allied Health Professionals and other key stakeholders and professional staff in its membership to ensure appropriate advice is provided throughout the process of strategy development, implementation and review.

What is the role of Directions?

Policy Position

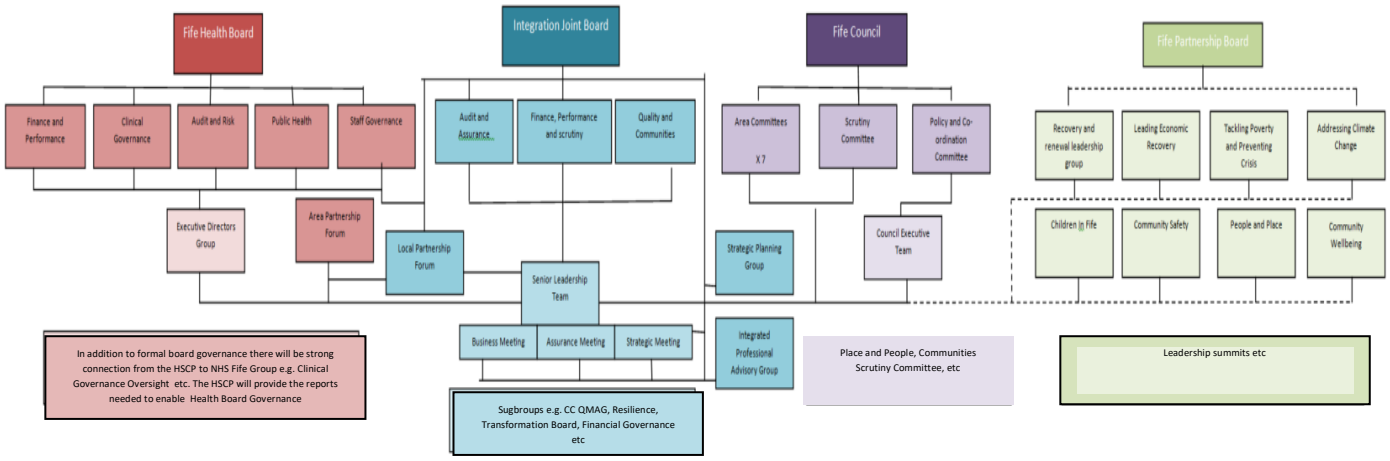
A policy on Directions has been approved by the IJB having being widely consulted with partners.

In line with Policy - Any direction issued by the IJB must meet all clinical and care governance requirements and standards to ensure patient safety and public protection as well as ensure staff and financial governance. Every IJB has senior professional, clinical and financial advisors as part of their core membership to provide scrutiny of these aspects and to provide assurance. This does not require to be remitted for additional checking through Local Authority of Health Board systems: Local Authorities and Health Boards should ensure that the professional and clinical advisors tasked to provide advice to IJBs are appropriately experienced and supported in their role. All direction to the IJB will come through IJB Quality and Community and IJB Finance, Performance and Scrutiny.



Where do services within the HSCP connect with and report to?

The Senior Leadership Team Connects with a wide range of Partners and this is reflected in our Reporting arrangements beyond SLT into: Fife Integration Joint Board, NHF Fife, Fife Council and Fife Partnership Board.



The key purpose of the Quality and Communities Committee is to provide assurance to the IJB in relation to its statutory duty, policy requirement and strategic approach around clinical and care governance, quality, safe and effective services, transformation, localities, communities and participation & engagement.

How is the Chief Officer establishing a framework of Assurance to aid good operational governance? **HSCP Position**

A mechanism has been established in the Health and Social Care Partnership to support assurance. This includes huddles reviewing data, to clinically led portfolio groups which enables focused discussion on service specific quality matters e.g. mental health, community hospitals, children's services, this then feeds into an overarching Clinical and Care Quality Assurance Group (QMAG) which receives reports from portfolio groups and this then feeds into Senior Leadership Assurance which receives assurance, reassurance and escalation on a range of issues e.g. quality, health and safety. This then reports into the organisational governance structures and all appropriate clinical matters will be reported to the Clinical Governance Oversight Group.

Senior Leadership Assurance Group: Chaired by the Director of Health and Social Care. Clinical and Professional Membership includes Deputy Medical Director, Associate Director of Nursing, Deputy Director of Pharmacy, Director of Psychology, Associate Director AHPs and Principal Social Work Officer. Subject matter experts attend according to the agenda. The group receives reports from the topic specific subgroups including Clinical and Care Quality Assurance Matters Group; Health and Safety Forum; Resilience Forum; Risk Management; Localities Participation & Engagement on the basis of assurance, reassurance or escalation. The value of this forum is that it enables cross-fertilisation, provides senior leadership oversight and supports good governance across the structures recognising the system complexity.

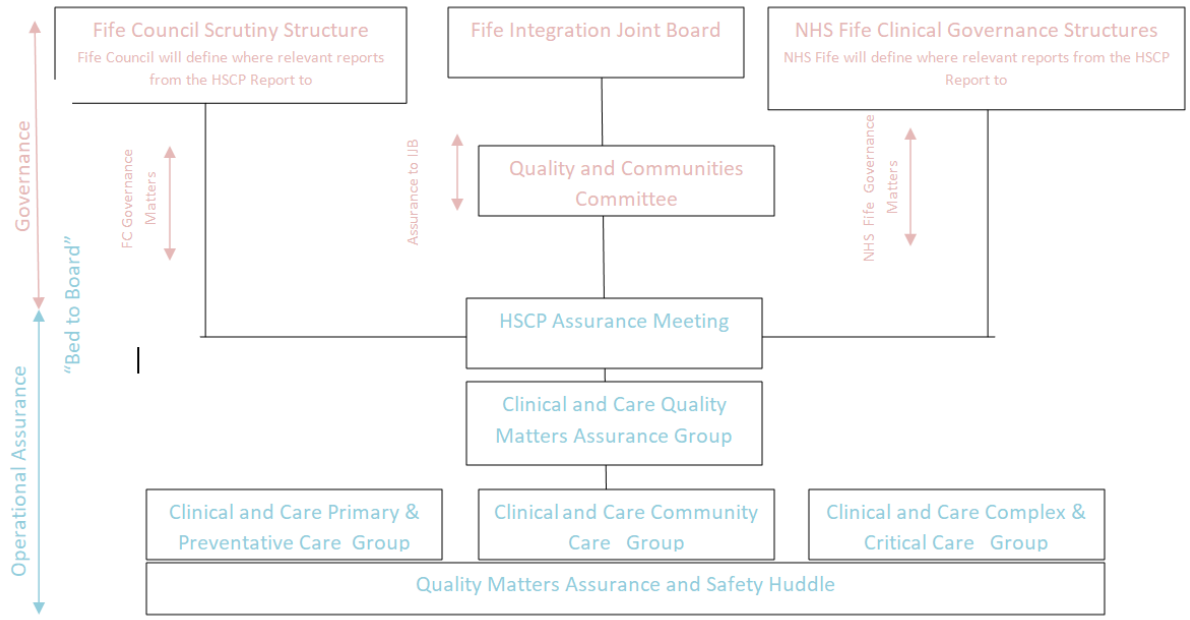
Clinical and Care Quality Matters Assurance Group (QMAG): This is a clinically/professionally led forum. This forum covers all delegated services. The work of the forum adheres to the policies and procedures of NHS Fife and Fife Council. The QMAG enables clinical & Care governance within the HSCP and provides assurance to the Senior Leadership Team Assurance Group that clinical and care governance is discharged effectively within the partnership whilst meeting the statutory duty for the quality of care delivered specifically in relation to patient/client safety, clinical effectiveness and patient/ client experience using a person centred, rights based approach and which can be evidenced using Integration Governance Principles: "How Do You Know"? It covers all delegated services including clinical issues, care issues and integrated issues and there are strong connections through membership to other CCG forums.

Portfolio Clinical and Care Assurance Groups: Each of the three operational portfolios have clinical and care groups. These are clinically and professionally led and reports into CG QMAG. The groups will provide multi professional oversight of all quality data outcomes including adverse incident data, LAER, SAER, External and Internal Inspections, learning from audit and data, feedback and compliments / complaint information, Quality Improvement projects and development of new services as they relate to the specific portfolio of Services e.g. Primary and Preventative Care, Community Care and Complex and Critical Care.

Huddle: There is a fortnightly clinically and professionally led huddle. This enables a review of data including incidents e.g. falls, medication, violence and aggression, tissue viability. Integrated data sources are in development.

In addition: The above arrangements continue to evolve given the restructure was during a pandemic. There are reporting lines from the professional leads direct to Executive Director Clinical Leads. There is Senior Clinical Representation from HSCP on all of the key NHS Fife clinical related groups e.g. infection control, clinical governance oversight group etc. A report will be provided to the Clinical Governance Oversight which details what is being actively discussed in the HSCP and provide assurance, reassurance or escalation and to enable further scrutiny and this can be managed to ensure appropriate reporting e.g. NHS Fife Business to NHS Fife and Fife Council Business to Fife Council and Integrated Business to IJB through Quality and Communities. The diagram on the next page aims to describe this system connection. The recent inspection has recognised QMAG as a good example of integrated arrangements.

System Connection



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Report on Outcomes from Existing Clinical Strategy**
Responsible Executive:	**Chris McKenna, Medical Director** **Margo McGurk, Director of Finance and Strategy**
Report Author:	**Susan Fraser, Associate Director Planning and Performance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- NHS Board strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Clinical Strategy was produced in 2016 and provided the strategic direction of travel for health care services in Fife between 2016-21. Working is currently under way to write the Population Health and Wellbeing (PHW) Strategy.

This report summarises feedback from clinical teams on the progress made against the recommendations of the Clinical Strategy.

2.2 Background

The Clinical Strategy made 19 recommendations that were derived from the report recommendations from the 7 clinically led workstreams. The published strategy also included *Recommendations in Practice* that have been used to review and critically appraise the progress made since 2016.

The paper outlines the 4 main transformation programmes that were prioritised from the Clinical Strategy namely:

1. Acute Services Transformation: reduction in unwanted variation, standardisation, redesign of services in line with Realistic Medicine and Regional working
2. Community Redesign: Urgent Care Redesign, development of Community Hubs and community hospital redesign
3. Mental Health Redesign
4. Medicine Efficiencies

Reporting of progress against programme plans for each transformation programme was provided as assurance to the Clinical Governance Committee on a regular basis since 2016.

2.3 Assessment

Feedback was received from the chairs and teams of the workstreams involved in writing the Clinical Strategy in 2016. Progress was documented then summarised in the attached paper.

The seven workstreams from the Clinical Strategy were:

1. Urgent Care Workstream
2. Scheduled Care
3. Chronic Conditions
4. Cancer Services and Palliative Care
5. Women And Children's Services
6. Mental Health and Learning Disabilities
7. Estates, Digital & Information and Support Services

The summary of the main achievements is presented as well as (1) an indication of whether the recommendations in practice has been achieved or not and (2) alignment of the recommendation in practice to NHS Fife's current strategic priorities.

The feedback indicated that significant work had been carried out in most areas which also reflected changes in services during the COVID period. In many cases, although the original recommendations in practice had been achieved since 2016, similar pieces of work are ongoing or still relevant in a slightly different form reflecting changes in national policy and local focus.

In many cases, a local strategy/strategic framework has been produced outlining key priorities for services going forward. The paper captures the strategies and strategic frameworks aligned to the new PHW strategy.

The feedback from clinical teams including the review of the Clinical Strategy, will be used to inform the Population Health and Wellbeing Strategy and the associated delivery plans.

2.3.1 Quality/ Patient Care

The Review of the Clinical Strategy summarises the improvements in quality and patient care since the publication of the Clinical Strategy.

2.3.2 Workforce

Workforce was a key to the delivery of the previous strategy and this is demonstrated in the changing profile of the workforce and importance placed in the PHW Strategy.

2.3.3 Financial

The financial pressures were managed over the years of the Clinical Strategy. Financial pressures were, where practical, found within existing budgets.

2.3.4 Risk Assessment/Management

The risks associated with this work were identified and managed through the Board Assurance Framework for Strategic Planning since 2016.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity including health inequalities were addressed in the Clinical Strategy 2016-21. An EQIA has been completed and signed off for the PHW Strategy.

2.3.6 Other impact

No other impacts are anticipated.

2.3.7 Communication, involvement, engagement and consultation

There was extensive public and staff engagement during the consultation for the Clinical Strategy.

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 (by email) 18 October 2022

2.4 Recommendation

The Committee are invited to take:

- **Assurance** on the significant progress made on the recommendations of the Clinical Strategy 2016-21 and continuation of areas of priority in the Population Health and Wellbeing Strategy.

3 List of appendices

- Review of the Clinical Strategy Draft Report 2016-21

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

Review of the

Fife Clinical Strategy

2016-21

Draft v1.1: 19 October 2022

VERSION CONTROL

Draft V 1.0	18/10/22	First draft distributed to EDG
Draft v1.1	19/10/22	Revised draft following comments from EDG

CONTENTS

1 INTRODUCTION

In 2016 NHS Fife published its 5-year Clinical Strategy, outlining its key priorities and recommendations for the next 5 years. The Clinical Strategy 2016-2021 was developed in partnership with a wide range of stakeholders and described the future model of healthcare for the people of Fife. This was facilated by the creation of 7 mulitprofessional work streams.

1. Urgent Care
2. Scheduled Care
3. Chronic Conditions and Frailty
4. Cancer, Palliative Care and End of Life Care
5. Woman and Children
6. Mental Health & Learning Disabilities
7. Estates, Digital & Information and Support Services

19 key recommendations in the Clinical Strategy were produced from individual workstream reports.

The progress in the delivery of the key recommendations have been affected by the unprecedented demands of the Covid pandemic and the consequent impact on NHS Fife health and social care systems. This report aims to detail the progress clinical teams have made towards the recommendations set out in the strategy while recognising the context in which we are now developing our new Population Health and Wellbeing Strategy has changed dramatically since 2016.

The report will hence be a light touch acknowledgement of the ambitions set out in 2016 and will major on the need to focus on moving forward, yet still being cognisant of the excellent work completed and the need to recognise that areas of development remain a work in progress and will carry forward into the next generation of clinical and care system development.

This report was collated by working with clinical and managerial teams across Acute Services and the Health and Social Care Partnership. Feeding into existing management and clinical groups mindful of the impact on individuals and teams time given the ongoing significant service pressures.

2 2016-2021 Clinical Strategy Summary

'The main ambition of the strategy was to shape the delivery of healthcare in Fife over the next five years and beyond and was the Boards' response to the changing needs of a rising and ageing population'

The following guiding principles where used:

1. The provision of services will be needs based, proportionate, person centred and developed in partnership with people.

2. A whole system approach to support and services will be adopted across health and social care and other agencies.

3. Where appropriate, support and services will be delivered as close to people's home as possible in a timely manner.

4. The provision of all health care will be value based in terms of outcomes, efficiency of resources and cost effectiveness.

5. People will take responsibility for their own health with a focus on prevention and early intervention and avoidable admission into hospital

3 Workstream Updates

Each workstream produced a number of recommendations which were refined to a set of recommendations in practice and 19 key recommendations. The Recommendations in Practice have been used for each workstream to provide evidence of progress.

Status will be completed based on review of progress and recognising changes or updates in strategic direction.

3.1 Urgent Care Workstream

Recommendations in Practice

Urgent care pathways will be developed to optimise the patient experience through the input of the multi-disciplinary team.

Urgent care hospital services will be restructured to ensure they provide the best care for the people of Fife.

More urgent care services will be provided in the community rather than the acute hospital.

An electronic patient record accessible to urgent care professionals in all sectors will be developed.

Achievement	Status	Current strategic priority
Delivery of Urgent Care Centres following the Ritchie Report The number of urgent care centres were reduced and a shift to a multi-disciplinary approach was achieved successfully covering Out of Hours Services (Urgent Care). In late 2020, the national redesign of Urgent Care was implemented with the introduction of the Flow and Navigation Centre (FNC). This continues to be delivered. This has and will result in new models of care adopted, changing the way emergency and urgent care are delivered in Fife.	Completed but ongoing under new Unscheduled Care Collaborative	
Patient pathways In 2017, two community programmes were established: Community hubs and work with HHG individuals. Single point of access (SPOA) for community services was set up but has now transitioned into the Flow and Navigation Centre (FNC) with a SPOA for east and west Fife. Patient pathways in place include H@H, ICASS, Palliative Care and direct admission to Admission Unit 1 (AU1) Community huddles were set up with a multi-disciplinary team to support the management of community services.	Completed but ongoing	
Community Services The introduction of STAR beds in health and social care provides rehabilitation services to support patients on discharge to return to their place of residency, and on occasion can prevent an admission to Acute care. There are 29 STAR beds across Fife, accessed through social work, and are a step down for Community Hospital, acute care, and social work. The Pharmacy First service, which replaced the previous Minor Ailment Service, provides a patient centred and highly accessible route to care for those experiencing a wide range of clinical conditions. The Board has 14 contractors currently delivering direct care utilising independent prescribing skills.	Completed but ongoing	

Achievement	Status	Current strategic priority
Accessible Electronic Patient Records The Clinical Portal is now in place and accessible to clinicians across Fife and neighbouring boards. Morse was implemented in 2018/19 for Community Services. This has enabled Primary Care to access records and helped with High Health Gain work.		

Transformation work continues across Urgent Care and the community with the ambition to continue to improve and redesign the services.

3.2 SCHEDULED CARE

Recommendations in Practice
Reconfigure scheduled care services to optimise the achievement of best patient outcomes.

Better joined up pathways of care for scheduled care through primary and secondary care will be developed.

Develop one stop community investigation clinics.

Locality based clinics will be supported by specialist consultants.

Make better use of technology to provide care and support and avoid

Achievement	Status	Current strategic priority
Early Diagnosis Early Cancer Diagnosis Centre pilot started in 2021 has successfully diagnosed more patients than expected with vague but concerning symptoms. Given the success of the pilot, options to expand the remit of the service are being explored.	Recent development and ongoing	
Optimisation of Services The introduction of the jack and jill ophthalmology theatres at QMH in 2018 has significantly changed the ophthalmology surgical pathway and improved patient care. The introduction of Cytosponge, an innovative practice redirects patients to this new diagnostic modality reducing the	Completed but ongoing	

Achievement	Status	Current strategic priority
need for gastroscopy. Since 2021, Robotic Surgery has been introduced within three specialties (Colorectal, Gynae-oncology and Urology Cancer patients) and it is anticipated that this will attract high calibre candidates when future consultant posts are advertised in general surgery and urology.		
Joined Up Pathways Fife Referral Organisation Guidance (FROG) was developed during the COVID period and launched at the end of November 2021. This provides guidance on how referral information is managed between primary and secondary care. The establishment of a GP pathway for Irritable Bowel Syndrome (IBS) has improved the care of patients, within general practice or through signposting to other services. Phlebotomy services are now embedded in the community supporting scheduled care. Procedures of low clinical value and low volume surgery have continued to be reviewed and revised over the years. More collaborative regional working is in place that has supported a regional approach to clinical pathways as well as training opportunities	Completed but ongoing	

Locality based clinics and more community based scheduled care services were ambitious and for a number of reasons this was not progress although better access to all continues to be an ambition.

3.3 CHRONIC CONDITIONS

Recommendations In Practice

Make better use of technology to help and support people to manage their own health conditions at home.

All patients in care homes will have standardised health related documentation and anticipatory care plans.

Single multi-specialty clinics will be developed for people with multiple conditions.

Redesign of chronic management to be needs led and not age based.

Develop a sustainable workforce with appropriate skill mix and strong links to the 3rd sector to support people with chronic conditions and frailty. necessary return outpatient appointments.

Achievement	Status	Current strategic priority
Data sharing There are data sharing agreements in place where required but work is still required to make the system more seamless and integrated. There has been an improvement in the availability of hardware and software across services but there is still work to be carried out.	Ongoing	
Anticipatory Care Plans for Care Home patients Work began in 2016 to establish an electronic anticipatory care plan (ACP) known as eKIS, for patients with long term conditions. More progress was made as a response to COVID and as part of the Home First strategy work which requires GPs as only GPs can access and update the plan.	Completed	
Needs led Chronic Conditions Management A Single Point of Access is in place and links with Discharge Hub in Acute to enhance continuity of care. This service has supported by an MDT and provides care planning co-ordination. The development of Community Treatment and Assessment Centres (CTACs) to deliver a range of interventions for the community – for example, community phlebotomy, enhanced multi-disciplinary teams and immunisation services.	Partially completed but ongoing	

Achievement	Status	Current strategic priority
Improving Health and Wellbeing The Clinical Quality Clusters have been introduced in General Practice/Primary Care with the aim to improve population wellbeing, health, reduce inequalities and consider clinical priorities for the cluster population.	Completed	

3.4 Cancer Services and Palliative Care

Recommendations in Action

All opportunities to promote healthy lifestyles, screening uptake and early detection of cancer will be taken by health professionals.

We will develop and expand acute oncology services in Fife in line with the National Clinical Strategy.

We will develop single points of contact to help people with life limiting conditions access the right services, support, and advice at the right time.

Where possible, patients will have a unified and shared anticipatory care plans.

Cancer Services

Achievement	Status	Current strategic priority
Screening and early detection qFIT as a diagnostic tool has been implemented in Fife and is routinely used to support referral criteria. Bowel screening uptake is approximately 66% which is in line with the Scottish uptake.	Completed	
Service Developments The Macmillan Improving Cancer Journey is fully implemented, and the Single Point of Contact Hub will integrate and compliment the work already in place. Most patients now receive Systemic Anti-Cancer Treatment (SACT) in Fife with specialist treatment. In 2017, Dermatascopes were funded in GP practices to help detect early signs of skin cancer. In 2021 exploration of the use of Photo Triage has been taken forward.	Completed but ongoing through Cancer Framework	

Achievement	Status	Current strategic priority
Gaps in cancer services have led to clinical nurse specialist appointments in: Breast, Colorectal, Head & Neck, Lung, Gynaecology, Upper GI and Urological cancers and rarer cancers: Sarcoma, Brain/Central Nervous System and Cancer of Unknown Primary. Treatment summaries have not been implemented and are a key action in the Cancer Framework 2022 - 2025.		
Development of Oncology and other Services Within the last 5 years, an Acute Oncology nurse led service has successfully been introduced in Fife. A skill mix review resulted in the appointment of a nurse consultant in SACT and expanded roles for Advanced Clinical Nurse Specialists for Lymphoma, the Early Cancer Diagnosis Centre and Urology.	Completed but ongoing through Cancer Framework	

Palliative Care

Achievement	Status	Current strategic priority
Service Redesign The service was redesigned at pace in response to the Covid pandemic which involved reducing bed numbers and increasing the community input by providing increased clinical assessment and personal care at home. This has proved very successful.	Completed	
Digital Enablement Moving to the MORSE system has vastly improved communication and information sharing both within the specialist service and with other health care professionals.	Completed	

3.5 Women And Children's Services

Recommendations in Action
Redesign maternity and paediatric pathways with appropriate multidisciplinary workforce skill mix for the delivery of clinical services.

Develop a workforce that has the appropriate training and education to deliver future maternity and paediatric services.

Achievement	Status	Current strategic priority
Prevention and Wellbeing Achievement of UNICEF Gold accreditation for maternity and re-accreditation for NNU - re-designed the smoking cessation service and continued with alcohol brief intervention training/delivery.	Completed	
Service and Pathway Redesign Best Start Recommendations are ongoing with the workload workforce tool leading to a detailed review in midwifery. There has been an enhancement of the paediatric nursing establishment to improve sustainability within the service. Other development posts in midwifery include Midwife Educator role, Bereavement Midwife, Perinatal Mental Health Midwife/ Nurse, and Midwifery Care Assistant (MCA) role. In Community Child Health a psychologist has been introduced to support with the appropriate triage of patients.	Completed but ongoing under Women's Health Plan	
Digital enablement Badgernet has been implemented in Maternity and Neonatal Services but still being developed. Full EPR for NNU has not yet been agreed. Work is almost complete on migration of the Community Paediatric service to a single shared electronic patient record.	Ongoing	

Dedicated work under the auspice of the Women's Health Plan is underway across NHS Fife and Public Health with the aim of meeting the recommendations within the plan.

3.6 Mental Health And Learning Disabilities

Recommendations in Action
We will reconfigure mental health and learning disability services to ensure equity across Fife.

We will review and where appropriate reconfigure mental health inpatient sites across Fife.

A single point of access for emergency mental health advice and assessment will be available

Development of the liaison psychiatry service and community based multiprofessional teams.

Achievement	Status	Current strategic priority
Reconfiguration of Services Community Mental Health Teams (CMHT) for adult and older adult service are now in place providing care at home or as close to home as possible. Pathway building capacity within the third sector and self-management is the first step to deliver a robust, evidenced-based treatment with the CMHT development. A third sector (voluntary) review currently in progress will ensure that the right voluntary organisation will be providing services with the greatest impact.	Completed but ongoing in the Mental Health Strategy	
Inpatient Services A review of inpatient services is currently ongoing for Mental Health and will go to option appraisal and public consultation. National level development discussion continues for an inpatient unit in Scotland for Children and Young People Learning Disabilities Services (CYPLD). Support for an inpatient unit in Scotland for CYPLD is ongoing with NHS Fife continuing to support this in a collaboration with Scottish Government.	Completed but ongoing in the Mental Health Strategy	
CAMHS and PT Action 15 primary care workers are now in place which has improved the number of rejected referrals for treatment. Investment in CAMHS and PT has improved access to services with availability of 70% for one-to-one appointments for adults with PT/complex trauma work and meets need in different way. Changes in practice for those patients with personality disorders means patients are treated locally using an established care	Completed but ongoing through new priorities for CAMHS and PT	

Achievement	Status	Current strategic priority
pathway.		
Digital Enablement The Mental Health Service activity is recorded on TrakCare which included Community Psychiatric Nurses (CPNs). Trakcare is still used for referrals and activity, but MORSE is now implemented within the service. Drug monitoring service is delivered at day hospitals with the day hospital service now being part of CMHT.	Completed	

The recommendations on the development of mental health services have not been realised or there has been a change in practice which means they are no longer relevant. The Mental Health Strategy and subsequent transformation programme should address such recommendations as the older adults' MDT liaison psychiatry service and the development of a bio psychosocial model of care.

The CYPLD recommendations from the Clinical Strategy were not achieved. There is however a continued ambition to review CYPLD services to create a service in which a single CYLPD-MDT, which has a single management structure and single set of case notes, is co-located to enable partnership working with other agencies.

3.7 Estates, Digital & Information and Support Services

Recommendations in Action

Telehealth and Telecare will be used to aid self-monitoring of health condition.

Estate and facilities will be flexible and fit for purpose.

We will move to a paper-light system with an electronic patient record.

We will work to increase the uptake of people booking appointments and ordering repeat prescriptions using technology.

Achievement	Status	Current strategic priority
Telecare and Telehealth The Technology Enabled Care (TEC) programme ran in NHS Fife and Fife Health and Social Care Partnership focussed on supporting primary/community patients during 2017/8 and complemented the existing telecare work by Fife Council. There were 4 pieces of work: *Blood Pressure monitoring, SNAP40, Advanced Risk Modelling for Early Detection (ARMED), Near Me* Near Me was limited in its use pre COVID but was adopted quickly by clinicians to consult with patients virtually. This was adopted across primary, community, acute care and Mental Health by a range of clinicians.	Complete but ongoing under Digital and Information Strategy	
Property and Asset Management The onset of Covid-19 and the widespread utilisation of digital technology has meant that there is much scope for further delivery. Closer working relationships are now in place with Fife Council. There will be a trend towards agile working which will see a mix of home based and multi-site working environments. A key principle is the organisation making best use of space. Review of the estate has taken place for Primary Care and Mental Health inpatients. Progress has been made on the Fife Elective Orthopaedic Centre (National Treatment Centre in Fife) and the Lochgelly and Kincardine Health and Wellbeing Centres with opening dates in 2023.	Complete but ongoing under PAMS Strategy	
Pharmacy and Medicines Pharmacy has delivered increasing levels of direct clinical care by Pharmacists and Pharmacy Technicians over the last five years. In the primary care setting, Pharmacotherapy is a key component of wider GMS transformation, and the team is now 3-4 times larger than it was in 2016. Specialist pharmacy services, including the pain service, deliver clinics regularly while Pharmacy First Plus is embedded with a	Complete but ongoing under Pharmacy and Medicines Strategy	

Achievement	Status	Current strategic priority
plan for further growth.		

Implementation of Paperlite has been challenging and has been implemented where opportunities have arisen. This is an NHS Fife corporate objective for 2022/23

The ambitious recommendation of electronic prescribing has not been achieved but is also a corporate objective for 2022/23 and should be achieved in the next few years

4 Strategic Approach to Clinical Strategy 2016-2021

The implementation of the Clinical Strategy in 2016 was approached by identifying four key priorities for NHS Fife which underpinned all aspects of the Board's strategic planning at that time. These four priorities were:

1. **Acute Services Transformation** including reduction in unwanted variation, standardisation, redesign of services in line with Realistic Medicine and Regional working
2. **Community Redesign** including Urgent Care Redesign, development of Community Hubs and community hospital redesign
3. **Mental Health Redesign**
4. **Medicine Efficiencies**

Reporting of progress against programme plans for each transformation programme was provided as assurance to the Clinical Governance Committee on a regular basis. Any new programmes of work had to demonstrate alignment to the Clinical Strategy.

The Annual Operational Plans (AOP) submitted and agreed with the Scottish Government between 2017-19 highlighted these programmes as the key priorities for NHS Fife with progress described year on year.

On reflection, the focus and reporting of the 4 key priorities did not report to the governance structure all the good work, contained within the Clinical Strategy, being carried out throughout the organisation over the years.

5 CONCLUSION

The review of the Clinical Strategy 2016-21 was produced using detailed feedback from the clinical and managerial teams across NHS Fife and Fife Health and Social Care Partnership. In addition to the 4 transformation priorities that were taken forward at that time (detailed in the last section), a significant amount of progress has been achieved across the health and care services since the publication of the Clinical Strategy.

Going forward, the outcome of this review and the fuller feedback from teams will be used to shape the Population Health and Wellbeing Strategy and the associated delivery plans.

Dr Chris McKenna
Medical Director
NHS Fife
18 October 2022

Susan Fraser
Ass Director of Planning and Performance
NHS Fife

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Strategic Planning and Resource Allocation 2023-24**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This report is presented for:

- Assurance

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 describes the SPRA process and provides an update on the submission process.

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

Stakeholder feedback has suggested a workshop would be very helpful to stakeholders to provide guidance and support to completing and providing the requested information. Consequently, 5 workshops have been organised for the end of October and beginning of November as follows:

Tuesday 25th October, Estates & Facilities, 2pm - 4pm, Albert Room - VHK

Wednesday 26th October, WCCS, 11.30am - 1.30pm, HH Floor 2 Meeting Room

Wednesday 26th October, Corporate Directorates, 3pm-5pm, HH Floor 2 Meeting Room

Wednesday 2nd November, PCS, 9.30am - 11.30am, Lecture Theatre - VHK

Wednesday 2nd November, ECD, 2.30pm - 4.30pm, Lecture Theatre - VHK

Colleagues from Planning, Workforce and Finance will deliver several presentations to inform how the process will be taken forward, key outcomes to be delivered, and the many challenges we currently must balance alongside our ambition and delivery of our objectives. This will be followed by a walk-through of the SPRA template with some worked examples and opportunity to ask questions and seek any clarifications required to complete the process.

Templates for completion have been revised but will not be distributed until after the workshops are complete and will be further revised if required to take account of any points raised by stakeholders at the workshops. Templates will then be distributed and once returned, submissions will be collated and reviewed to report back to EDG in January 2023 on the proposed service changes and programmes that will be discussed and then prioritised. These service changes and programmes will be considered in terms of alignment to strategic priorities, quality of care as well as financial and workforce implications. Further workshops will be held in early January to provide feedback, enable further revision and information to be collated before submission to EDG.

Once completed, the governance of this work will be to provide a paper on the outputs from the SPRA process to the committees and through to the Board.

Key dates:

25 Oct-2 Nov	Workshops Held
4 November	SPRA Templates distributed to Directors
16 December	Deadline for SPRA submissions
January 2023	Workshop 2 – Feedback/further revision
January 2023	Summary of submissions to EDG followed by prioritisation
March 2023	Governance Committees
March 2023	Final SPRA report to Board

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 and Anchor Institution Ambitions

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

2.3.6 Climate Emergency & Sustainability 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, 20 October 2022

2.4 Recommendation

The Clinical Governance Committee are asked to:

- Take **assurance** on the Strategic Planning and Resource Allocation methodology and the timeline for delivery.

3 List of appendices

None

Report Contact
Maxine Michie
Deputy Director of Finance
Email: maxine.michie@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Annual Delivery Plan Progress & Winter Actions**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to Committee for:

- Assurance

This report relates to the:

- Annual Delivery Plan 2022/23

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This paper reports the status update as at end of September for deliverables submitted as part of the Annual Delivery Plan (ADP) for 2022/23. This was requested in ADP feedback letter received by Scottish Government on 21st September.

2.2 Background

The Annual Delivery Plan (ADP) for 2022/23 was submitted to Scottish Government at the end of July, including Deliverable Template with status as at end of June. Request for September update was received on 21st September with schedule in place for further updates that will be required for December and March.

The update for status at end of September, which included incorporating key actions for winter, was submitted to Scottish Government on 28th October.

2.3 Assessment

Key achievements and challenges/barriers to progress

Workforce

- Three-Year Workforce Plan is in the process of being published in December 2022
- Staff Health & Wellbeing Framework will be presented to Staff Governance Committee in November 2022
- Multi-disciplinary team has been established to deliver a range of workplace and related staff support services
- Recruitment of Band 2 to 4 Nursing & Midwifery roles has been increased
- Latest phase of our East Region Recruitment Shared Service model implementation has been completed
- e-Rostering implementation programme has commenced

Recovery and Protection of Planned Care

- Two year wait target for Outpatients will be met
- Routine, longer wait inpatient cases are able to be prioritised on the QMH site
- NTC Fife Orthopaedics expected to be operational on time
- Work is ongoing with specialities to optimise the CfSD driven tools, specifically ACRT and PIR
- The Maggie's Prehabilitation pilot has been rolled out in Fife
- Funding for Rapid Cancer Diagnosis Services has been confirmed for 2022/23
- 2 CT scanners being replaced without loss of activity due to the presence of a mobile CT unit
- Recovery plan funding not sufficient to deliver plan outlined
- Complex TTG cases cannot be prioritised on VHK due to urgent cases
- Activity continues to be restricted due to unscheduled care pressures
- Fife allocation of additional capacity to NTC has been reduced
- Lack of revenue funding for an additional CT scanner

Stabilising and Improving Urgent and Unscheduled Care

- High Impact Change Areas of focus for Fife have been identified
- Utilising data to better understand the pressures on our system, to target change ideas that will have the biggest impact prior to winter
- Testing of Emergency Nurse Practitioners supporting redirections to Minor Injuries at QMH is showing increased attendances through this pathway
- Initial feedback on the vision of Home First model, from engagement events, has been positive
- Through the continued implementation of the GMS contract (2018), we have been able to increase the wider multi-disciplinary support to all practices across Fife
- Overall attendances to the Emergency Department (ED) within Victoria Hospital (VHK) remain high
- Low discharge profile within the VHK and the impact of the workforce challenges

NHS Dental Services

- Public Dental Service has fully remobilised all aspects of care and epidemiology
- General Anaesthetic service for children is still limited by anaesthetic availability from the acute unit
- No practices across Fife are taking on new patients

Mental Health Transition and Recovery Plan

- Development of a CAMHS Urgent Response Team for young people is on track
- CAMHS additional workforce to ensure capacity to meet demand is approximately 92% complete

- Perinatal and Infant Mental Health service has transitioned to the management of CAMHS
- Regional workgroups established to address those elements of the national service specification for CAMHS
- Recruitment has been successful within Psychology General Medical Service in Clinical Health
- Medication Assisted Treatment (MAT) Standards 1 to 5 implementation plan is progressing
- Workplan developed to deliver tier 1 and 2 interventions for MAT Standards 6 and 10.
- Commissioned 3rd sector organisation provides peer support for patients with dementia across 6 meeting centres at various locations across Fife
- Tests of change have been established through the governance of the Neurodevelopmental Strategic Oversight Group
- Service plan has been developed for Fife HSCP Eating Disorder Service
- Proposal developed for locality based Mental Health and Wellbeing hubs
- Recruitment has been challenging in some areas on Psychology with posts requiring to be readvertised

Supporting and Improving Social Care

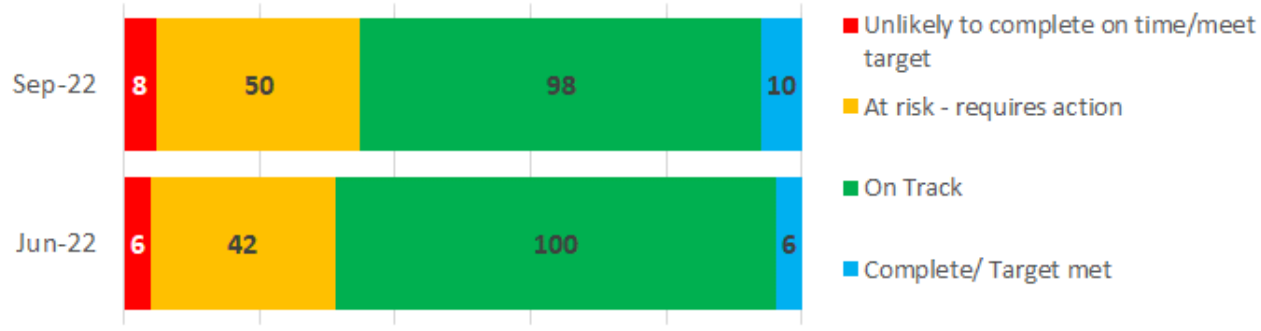
- Social Work working alongside the Hospital Discharge Team as part of the Front Door model to increase the speed of assessment
- New pathways in development ensuring care home residents have timely access to professional support and clinical advice
- New version of Smartlife in Fife service due for release in November
- Hourly rate to care at home providers has increased, in light of the ongoing costs of living increases especially around fuel costs

Sustainability and Value

- Where plans are slipping, pipeline schemes are being identified and are currently being worked up to come forward to the Financial Improvement and Sustainability (FIS) Programme Board for approval to move to implementation
- A Realistic Medicine Plan has been developed with timings and resources needed to ensure deliverables are met

Summary of High-Level Deliverables; June and September 2022

The graph below illustrates the status of the high-level deliverables in the ADP for June and September



Deliverables 'unlikely to complete on time/meet target' as at the end of September are listed below. Those in **bold** are changes from June status.

- Reducing long waits; Diagnostics, Outpatients and TTG
- Bed Modelling Exercise
- Re-patriation of breast screen-detected cancer surgery to NHS Fife
- Development of transition support for children with diabetes
- Radiology -7 day working
- Secure adequate funding to ensure minimal levels of service delivery for Spiritual Care
- **Maintain current Education Programme.**
- **Recover NHS dental services to a position comparable with pre-pandemic service provision with a focus on clearing the backlog in routine dental care and reducing oral health inequalities amongst children**

Deliverables 'completed/target met' as at end of September are listed below. Those in **bold** are changes from June status.

- Implementation of the recommendations of the AU2 QI project
- Remodelling of Service Management across W&C services including Community Paediatrics
- **Delivery of appointments by both technology and face to face as a hybrid provision for review appointments in MH and LD**
- Ensure sufficient and timely availability of social work staff for under 65s to ensure timely assessment and discharge, including where appropriate, to interim placements.
- Patient pathway developed to ensure streamlined flow of information from NHS 24 to Unscheduled Care to enable patients to be seen at the right time in the right place
- Successful transitioning of Public Health Covid response team including Test and Protect teams
- Embed Corporate Programme Management Office (PMO) to support service change across NHS Fife
- **Production and monitoring of NHS Fife Annual Delivery Plan for 2022/23**
- **Review and update of IPQR**
- **Pharmacy Robotics (PAMS)**

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the central to the aims and objectives of the ADP.

2.3.2 Workforce

Workforce implications arising from the ADP have been considered and have been included in the Strategic Planning and Resource Allocation process.

2.3.3 Financial

The financial implications of the ADP will be covered separately in the medium term financial plan for 2022/23.

2.3.4 Risk Assessment/Management

The management of risks are integral to the delivery actions of the ADP and will be reviewed on a quarterly basis.

2.3.5 Equality and Diversity, including health inequalities

Equality and diversity are considered in the delivery actions of the ADP and will be reviewed on a quarterly basis.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the implementation of the ADP.

2.3.8 Route to the Meeting

- EDG Comment – 24th October 2022

2.4 Recommendation

Committee is asked to:

- **Note** the status of deliverables from the Annual Delivery Plan 2022/23 at the end of September 2022.

3 List of appendices

The following appendices are included with this report:

- NHS FIFE ADP 2022_23 September Update

Report Contact

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Susan Fraser
Associate Director of Planning and Performance
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Update on Annual Delivery Plan 2022/23

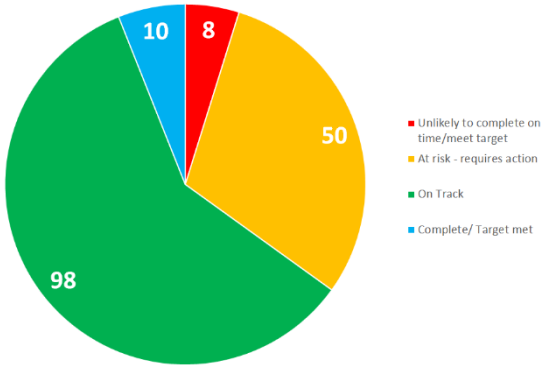
1 Introduction and Context

This is an update on progress to September 2022 relating to the Annual Delivery Plan for health and care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) for 2022/23.

Services were asked to update on achievements over the last 6 months and identification of any barriers preventing delivery of the actions.

2 Summary

Status of all deliverables at the end of September is detailed below. Additional deliverables have been added in relation to winter readiness. There were four deliverables completed from position at end of June with two further unlikely to be completed on time.



3 National Priorities

3.1 Workforce

3.1.1 Three Year Workforce Plan

NHS Fife's Three-Year Workforce Plan is in the process of being published in December 2022, following Scottish Government feedback. The activity within the plan outlines how we integrate support for our employees to stay well, into all of our work and takes account of the 5 Pillars of the Workforce journey: Plan, Attract, Train, Employ and Nurture.

3.1.2 Staff Wellbeing

The NHS Fife Staff Health & Wellbeing Framework, developed in partnership, will be presented to our Staff Governance Committee in November 2022. The Framework details the range of initiatives and services in place and to be developed that will facilitate our employees to stay healthy and well at work. The Framework also enables

the ongoing review of the effectiveness of our work in this area to maximise the benefits/outcomes for our employees.

A multi-disciplinary team, including Occupational Health specialists, Health Promotion, Psychology and Spiritual Care professionals, has been established to deliver a range of workplace and related staff support services. This work will be co-ordinated by the Staff Health and Wellbeing Group.

3.1.3 Recruitment and Retention

Recruitment of Band 2 to 4 Nursing & Midwifery roles has been increased to utilise additional Scottish Government funding and introduced our International Recruitment service, which is on target to recruit our initial aim of 40 Nurses and 3 Radiographers.

Work on developing local progression opportunities through our Employability programme has included a range of activities to identify and deliver enhanced training and job support to our local communities with the Kickstart initiative being a positive organisational commitment, continuing from our commencement of a dedicated programme of work in 2021/22.

Our immediate aims on workforce sustainability have directed efforts on recruitment as noted below in our Winter readiness activity and progressing Mental Health workforce priorities.

Latest phase of our East Region Recruitment Shared Service model implementation has been completed. This is to create a modern, sustainable recruitment function as well as using innovative recruitment approaches through targeted local and national campaigns aimed at targeting a range of job groups.

The e-Rostering implementation programme has commenced this year, and this will be a key element of our workforce planning activity with key links to both financial sustainability and safe staffing activity.

3.2 Recovery and Protection of Planned Care

3.2.1 Planned Care Activity

Enhanced infection control procedures were stepped down at the end of September, but the pressure of unscheduled care continues to impact on outpatient and inpatient capacity. There is a continued focus on urgent and cancer patients along with those who have been waiting more than 18 months and 2 years.

The new recovery plan was submitted to the Scottish Government but disappointingly the funding received was not what was expected and is not sufficient to deliver the plan outlined. Additional activity planned to deliver the new long waiting targets has been paused whilst the impact and revised plan are developed. No additional activity

has been undertaken since April apart from Breast Surgery outpatients to maintain urgent waiting times.

The two year wait target for Outpatients will be met however lack of funding compromises delivery of the December and March targets with Colorectal patients most at risk of being affected.

Inpatients and daycases have waited over 2 years and there is no plan to list patients on the Victoria Hospital (VHK) site. Routine, longer wait inpatient cases can be prioritised on the Queen Margaret Hospital (QMH) site however complex cases cannot be prioritised on VHK site due to the focus on urgent cases and the lack of capacity due to boarding patients.

Sustaining the current level of activity is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from absence and vacancies.

Every effort has been made by both management and clinical teams to move as much activity as possible to QMH. There are plans early 2023/24 for an additional theatre within QMH following refurbishment work to create a further local anaesthetic room.

Completion of the National Treatment Centre (NTC) Fife Orthopaedics remains on track, with the facility expected to be operational by January 2023. The Fife allocation of the additional capacity has been reduced to 26 patients from 336 patients which will mean that the backlog of Orthopaedic patients will increase month on month. The Director of Acute Services is continuing dialogue with colleagues in Scottish Government on this matter.

3.2.2 Centre for Sustainable Delivery (CfSD)

Regular meetings are scheduled with CfSD leads following each month's Heatmap submission to ensure connectivity and opportunity for prioritised specialties. Work is ongoing with specialities to optimise the CfSD driven tools, specifically ACRT and PIR.

3.2.3 Supporting patients to wait well

Patients who have been waiting a long time receive regular written communication to confirm they still require their procedures or to be seen and are provided with a number to contact if they have any concerns or if their condition has worsened.

3.2.4 Cancer

The Maggie’s Prehabilitation pilot has been rolled out in 8 centres across Scotland including Fife. There are weekly universal sessions for anyone with a cancer diagnosis at any stage with any prognosis. The pilot is promoted via local groups and social media. Over 90% of patients who visited feel they can make positive changes to their wellbeing.

Funding for Rapid Cancer Diagnosis Services has been confirmed for 2022/23, the service is running well with a conversion rate to cancer of 14%. Referrals are increasing and all professionals in primary care are encouraged to refer. Discussions are ongoing for consideration of a proposal to test a direct referral route from community pharmacy and looking at adopting the principles of the service into Hepatobiliary and Upper GI pathways. The service has reached the finalist stage in the Scottish Health Awards for Innovation.

3.2.5 Recovery of diagnostic activity

The new recovery plan, which included a sustainable workforce plan, was submitted to the Scottish Government but unfortunately the funding received was not what was expected. Further additional Radiology and Endoscopy activity has been paused whilst the impact and revised plan are developed.

Whilst Radiology activity is greater than projected there are challenges with ultrasound capacity. Within the Endoscopy service, no additional activity has been undertaken and core activity continues to be restricted due to unscheduled care pressures.

There is a continued focus on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits.

Sustaining the current level of activity is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from absence and vacancies. It is anticipated that performance will continue to be challenged due to the demand for urgent diagnostics which has now reached 52% of all referrals in radiology and the pressure from unscheduled care.

The replacement of imaging equipment has gone well in 2022/23 with two CT scanners being replaced without loss of activity due to the presence of a mobile CT unit. However, reducing the backlog is at risk due to lack of revenue funding for an additional CT scanner.

3.3 Stabilising and Improving Urgent and Unscheduled Care

3.3.1 Urgent and Unscheduled Care

Following the launch of the national Urgent and Unscheduled Care Collaborative in June, the Unscheduled Care Programme team completed the self-assessment requested by Scottish Government. This identified the following High Impact Change Areas of focus for Fife:

- Care Closer to Home
- Redesign of Urgent Care
- New Models of Acute Care
- Discharge without Delay

Within each of these priority areas, improvement plans will be further developed with key trajectories and linkage to key performance measures. Along with reporting to the national team, all high impact change areas have operational delivery groups in place reporting to the integrated Unscheduled Care Programme Board on a monthly basis, and onwards to the Portfolio Board.

We have sought, through utilising data to better understand the pressures on our system, to target change ideas that will have the biggest impact prior to winter. These include:

- Increasing pathways available to the Scottish Ambulance Service via our Flow and Navigation Centre, including social care, community respiratory teams and Hospital at Home
- Rapid enhanced senior clinical assessment of Primary Care presentations to our Medical Assessment Unit
- Introduction of virtual ward rounds for patients boarded out of their specialty ward or within a surge ward, to improve discharge planning.

Planning is currently in place to create better health infrastructure around our Care Homes, which includes better access to community-based services such as Hospital at Home and improved Anticipatory Care Planning. Supporting this further, plans are in place to create better Urgent Care support to care homes, both in and out of hours. This will include improved access to Urgent Care Advanced Nurse Practitioners in hours to all Care Homes, providing responsive and proactive support. Out of hours, we are currently trialling direct access for Care Homes to our GP Out of Hours Service, with the intention to roll this out from early November.

Testing of Emergency Nurse Practitioners supporting redirections to Minor Injuries at QMH is showing increased attendances through this pathway, but overall attendances to the Emergency Department (ED) within VHK remain high. Performance is largely impacted by the low discharge profile within the VHK and the impact of the workforce challenges across the whole site.

Work is ongoing with teams to maximise alternative pathways and reduce ED attendances, including admissions unit pathways. The Operational Escalation Framework (OPEL) triggers are under review to ensure scoring metrics accurately reflect whole site position.

Engagement events on the Home First model are actively underway. Initial feedback on the vision for the service has been positive with useful points raised to inform the detail of the Home First Strategy and intended future projects needed to define a Single Point of Access model.

Subgroups have completed several of their previously identified key actions/projects. The output from the current stakeholder events will see such areas re-focus contributions to the intended cross cutting strategic projects around the new model.

The Front Door model is progressing. This Programme will support greater understanding of all teams and services in scope, inform the mapping of current ways of working and help to identify measurable benefits.

A new coordinator has been appointed in relation to embedding Planned Date of Discharge (PDD) across Fife. This is currently being implemented in 4 wards across Acute Services and Health & Social Care.

3.3.2 General Practice appointments

NHS Fife GP Practices continue to offer a combination of face-to-face, telephone and virtual consultations. This is supported by a wider multi-disciplinary team (MDT) of Physiotherapists, ANPs, Treatment Care nurses and pharmacists, supporting GPs as senior expert generalists.

Through the continued implementation of the GMS contract (2018), we have been able to increase the wider multi-disciplinary support to all practices across Fife. In terms of the three priority areas outlined within Memorandum of Understanding 2 (MOU2) we have successfully delivered the Vaccination Transformation Programme (VTP), rolled out 65% of scoped Community Treatment and Access Centre (CTAC) Services and continue to develop our Pharmacotherapy services whilst awaiting clear National Guidance. Furthermore, our multi-disciplinary resilience team will commence in post by the end of November, which will support the wider work on maintaining sustainability across General Practice.

We are awaiting outputs from current trials taking place across Scotland in terms of localised GP activity Data.

3.3.3 Winter Readiness

Capacity and Flow meetings, consisting of Senior Managers and Strategic Planning colleagues amongst others, continued throughout the year recognising ongoing pressures on health and care system. Planning for winter 2022/23 began in May with a workshop to collate views from wider clinical teams across NHS Fife and the Fife Health & Social Care Partnership on what went well during 2021/22 and what changes are required ahead of the forthcoming winter period.

A further workshop has taken place, with themes considered and incorporated into deliverables within the Annual Delivery Plan (ADP). A further Acute Services focussed workshop is planned for the end of October, output will be incorporated into ADP in due course.

The recently received Winter Checklist is to be discussed and completed, with input from services and relevant output also to be included within the next ADP update.

The table below details deliverables that will be linked to Winter Readiness:

Deliverable	Lead
Discharge without Delay	Emergency Care
Review and Development of OPEL - Acute	Emergency Care
Band 2 Pool	Emergency Care
Maximise utilisation of QMH Theatres	Planned Care
Deliver Home First and enable Prevention and Early Intervention	Community Care
Continue to reduce delayed discharge	Community Care
Review and Development of OPEL - HSCP	Community Care
Redesign of Urgent Care in close working with partners	Primary & Preventative Care
Delivery of the Autumn/Winter Seasonal 22-23 Flu & COVID vaccination programme for eligible population in Fife	Primary & Preventative Care
eRostering	Digital
Optimise communications with all clinical teams in Acute Services and HSCP	Infection Control
Updating of Business Continuity plans	Public Health
Pharmacy First/Pharmacy First Plus Delivery	Pharmacy
Supporting the Health and Wellbeing of our Staff	Workforce
Attracting & Recruiting Staff to deliver Clinical and Workforce Strategy	Workforce
Internal and External Communications relating to Winter	Communications
Expand the reach of performance benchmarking and national planning initiatives	Planning

3.4 NHS Dental Services

The Public Dental Service has fully remobilised all aspects of care and epidemiology.

General Anaesthetic service for children is still limited by anaesthetic availability from the acute unit with access difficulties in practice continuing. No practices across Fife are taking on new patients therefore contributing to a mounting strain on daily emergency services whilst recruitment remains unsuccessful.

To facilitate access to care, an area wide review of patient lists is being undertaken.

3.5 Mental Health Transition and Recovery Plan

3.5.1 Mental Health Strategy

A review of the local Mental Health Strategy is underway and will be informed, in due course, by the publication of the revised national strategy, expected in April.

The Mental Health project team, in partnership with the operational team is developing the key building blocks. Engagement with our stakeholders will be led by the Mental Health Project Team and supported by the HSCP Participation and engagement team.

3.5.2 CAMHS

The development of a CAMHS Urgent Response Team for young people is on track with all posts recruited to and due to be in position by end of October. Revised job plans are in development to ensure clinical provision is sustainable.

Recruitment of additional workforce to ensure capacity to meet demand is approximately 92% complete, with all posts either recruited to or in the process of appointment. All core service posts are now filled which has resulted in adequate capacity to manage current demand.

The Perinatal and Infant Mental Health service has transitioned to the management of CAMHS to ensure alignment with other Perinatal and Infant Mental Health and Learning Disability services.

Regional workgroups have been established to address those elements of the national service specification, specifically forensic service, secure inpatient units, inpatient pathways, and unscheduled care.

3.5.3 Psychological Therapies

Recruitment has been successful within General Medical Service in Clinical Health including specialist with expertise in Functional Neurological Disorders. Additional resource is significantly reducing waiting time for assessment.

However, recruitment has been challenging in other areas with posts requiring to be readvertised including Unscheduled Care Brief Psychological Intervention Service vacancy that was not filled during recent recruitment round.

3.5.4 Alcohol and Drugs Partnerships (ADPs)

Medication Assisted Treatment (MAT) Standards 1 to 5 implementation plan is progressing:

- Same day prescribing is available at Methil Drop in and same day treatment further implemented at two static sites whilst LAIB (Long acting injectable buprenorphine) uptake is progressing.
- Addiction Services nurses have attended Methil Drop in since end of July with rapid access to treatment provided from September. Rapid access clinics in Kennoway and within Lynebank Hospital, Dunfermline commenced in September.
- Hospital Liaison Service is to continue following recruitment to pharmacy role within the team.

- Mapping work has commenced with Criminal Justice Social Work, SACRO (Scottish Association for the Care and Resettlement of Offenders) Custody Navigation Project and Phoenix Futures Prison Inreach to implement Standards 1 and 2 within justice settings.
- Embedding of Standards 1 to 5 is being progressed with a short life working group measuring progress in harm reduction practice and vaccination delivery.
- Workplan has been developed with Alcohol and Drug Partnership services for the improvement and workforce development required to deliver Tier 1 and 2 interventions (Standards 6 and 10).

3.5.5 Dementia - Post Diagnostic Support

Fife HSCP have commissioned STAND (Striving for A New Day), a 3rd sector organisation, to provide peer support for patients diagnosed with dementia. They now provide 6 meeting centres at various locations across Fife, providing a key contribution to our range of supports for people experiencing dementia, and their families.

3.5.6 Neuro-developmental Pathway

In partnership with, and investment from Fife Council and through the governance of the Neurodevelopmental Strategic Oversight Group, two tests of change have been established.

- Collaboration with Educational Psychology and Schools in West Fife was established to deliver immediate, proportionate intervention and support to young people with neurodevelopmental needs. This is already delivering a reduction of some 42% of individuals being referred on for Autism Assessment.
- Mental Health OT post, situated with 3rd Sector One Stop Shop, to provide clinical input, assessment, guidance, and signposting to people with Autism/ Neurodevelopment needs was appointed to in August.

3.5.7 Eating Disorders

Fife HSCP Eating Disorder Service have developed a service development plan which will provide a significant boost to multi-disciplinary capacity, recruitment is underway to deliver this.

3.5.8 Perinatal and Infant Mental Health

Both a targeted service within the wider community and specialised interventions for individual infants and their caregivers is being provided.

Expertise within the team means that individualised, specialist interventions can be made in ways that can be adapted to support the emotional wellbeing needs of infants. Targeted work in the wider community is also supported through links with 3rd sector

agencies to share learning and to ensure that the Voice of the Infant is prioritised in all settings.

3.5.9 Mental Health & Wellbeing Teams in Primary Care

A Multi-Disciplinary Oversight group has been established, reflecting colleagues from Mental Health, Primary Care and 3rd sector. This working group has developed the proposal for the development of locality based Mental Health and Wellbeing hubs, which is a cornerstone of the refreshed local Mental Health strategic direction.

Work is in the final stages to commission people with Lived Experience who will, supported by Officer colleagues, plan, prepare and initiate co-production of a design for hubs in three localities in year 1, expanding to all 7 localities in year 2.

3.5.10 Mental Health Officers

Fife HSCP have invested significantly into the Mental Health Officer service, to enhance capacity for the range of statutory requirements associated with both the Mental Health (Care and Treatment) (Scotland) Act and the Adults with Incapacity Act.

The investment is being used to employ an additional team manager and eight Mental Health Officers (MHO) resulting in two teams covering East and West Fife. Recruitment is in the final stages with majority of posts now filled.

There is a fundamental contribution to the support for Flow and Navigation, addressing and preventing delayed discharge across the system for those patients who lack capacity to make informed decisions regarding their welfare. MHOs will therefore directly contribute to the Hospital Discharge Teams and the evolving front door model.

3.6 Supporting and improving social care

Planned Date of Discharge (PDD) is now part of the Discharge Without Delay Programme. Social Work have been working alongside the Hospital Discharge Team as part of the Front Door model to increase the speed of assessment, but also to signpost to the community, where appropriate, in order to avoid admissions and create greater capacity within the hospital and the social work teams.

The next phase of developing the service provided by the Care Home Assurance and Support Nurse Team, is ongoing in partnership with colleagues. This work will create new pathways ensuring care home residents have timely access to professional support and clinical advice with the aim of preventing unnecessary admissions and enabling planned interventions to keep residents safe in their own home. Care Homes are also supported with Anticipatory Care Planning processes.

The Smartlife in Fife Service continues to be provided to the people of Fife and specific services on a 24/7 basis with new version due for release in November, this includes Life Curve component as well as additional insight module. Once implemented, there

are plans to increase staff access within other areas of Fife Council such as Housing. In addition, it is hoped there will be increased visibility of information held in the system which is available to other areas, for example, GP's and District Nurses. This will help support people to maintain their existing abilities as they age, as well as assist services to plan for future service provision.

The Home First Strategy is currently being implemented across Fife, this comprises of distinct project sub-groups that drive the strategy aims and objectives. One of these sub-groups relates to Anticipatory Care Plans (ACP) with agreement for a single ACP tool to be rolled out across Fife, firstly across the 8 Partnership Care Homes and 7 Independent Care Homes. Following the successful roll-out of the ACP and evaluation in early 2023, the sub-group will focus on supporting the roll-out of the Life Curve App within Care Homes and the wider community that will feed into the ACP and allow older adults the option to identify areas of their life they may need support with and what community groups or services exist that can help them.

Fife HSCP has also increased the hourly rate to care at home providers by 80p per hour, in light of the ongoing costs of living increases especially around fuel costs, which will be passed on directly to care staff to cover the additional costs incurring in delivering care.

3.7 Sustainability and value

3.7.1 Financial Improvement and Sustainability

At the end of August, the Cost Improvement Plans (CIPs) are £1.6m behind target, £0.9m on Grip and Control, £0.5m Acute Services and others of £0.2m. The forecast outturn assumes all CIPs will be delivered at the financial year end. Where plans are slipping, pipeline schemes are being identified and are currently being worked up to come forward to the Financial Improvement and Sustainability (FIS) Programme Board for approval to move to implementation. Whilst the final cost improvements delivered may differ in some respects from the approved schemes, all Senior Responsible Officers are working toward delivering CIPs totalling £11.7m in year and on a sustainable basis wherever possible.

The Director of Finance & Strategy has written separately to the Director of Health Finance, Scottish Government outlining the mid-year financial review position, the extent of the significant financial challenges and the ongoing actions to mitigate these challenges as far as possible.

3.7.2 Realistic Medicine

A Realistic Medicine Plan has been developed with timings and resources needed to ensure deliverables are met. The plan also contains activities to mainstream Realistic Medicine in Fife as well as develop digital strategies that enable Realistic Medicine.

Following engagement with stakeholders a Communications and Engagement Plan has been developed to spread the message about Realistic Medicine to staff, patients, relatives, the community, and other stakeholders. This includes lectures to students at the University of St Andrews and meetings to discuss the management of chronic diseases and frailty, with a focus on pain management and realistic prescribing.

4 Summary

This paper outlines the achievements made in the first 6 months of 2022/23 in line with the agreed Annual Delivery Plan. The delivery of the actions is detailed in the Delivery Action Plan and reported through the NHS Fife governance structure.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Laboratory Information Management System (LIMS) Update**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Donna Galloway – General Manager Women Children and Clinical Services** **Alistair Graham – Associate Director of Digital & Information**

1 Purpose

This is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective

2 Report summary

2.1 Situation

This paper presents an updated position on the risk associated with the Laboratory Information Management System (LIMS) replacement project, being delivered as part of the National LIMS Consortium.

Having completed several months of due diligence and analysis on the most appropriate approach for the rapid implementation of the LIMS system and to reaching a minimum "safe" system build, configuration and test status by March 2023.

The paper is provided at a time when NHS Fife has concluded the necessary governance to award the contract to Citadel, the supplier awarded the national consortium framework.

This paper seeks to provide a description of the known risks of this project and the suggested approach to monitoring and reporting progress.

The report is provided to CGC members for **assurance**.

2.2 Background

Following the award of the national LIMS Consortium Framework to Citadel, and not NHS Fife's existing LIMS supplier CliniSys, NHS Fife received notice from CliniSys of an intention to decommission the existing LIMS system, LabCentre, at the end of March 2023. This notice was supplemented with an offer to implement their WinPath Enterprise system as an alternative.

NHS Fife agreed to work alongside the five other Clinisys Boards, from March 2022 to August 2023, to formulate a response to the risks posed by the withdrawal of the LabCente system in March 2023.

A subgroup was formed to seek advice and support from National Services Scotland (NSS) procurement and Central Legal Office (CLO). The subgroup was also supported by members of the National LIMS Programme Board and National Programme team. The group pursued several options and met with both CliniSys and Citadel to explore the least risk strategy to move from the LabCentre product by March 2023. These meetings were supplemented by some of the Chief Executives meeting with both CliniSys and Citadel.

Following the completion of this work, NHS Fife's Board concluded on 17 August 2022, that it was appropriate to reject the offer made by CliniSys to implement their WinPath Enterprise system and to move to Full Business Case for the award to Citadel. The Full Business Case was agreed by the Finance, Performance and Resource Committee on 17 August 2022.

Work with Citadel has been ongoing, during this period of time, with the support of the LIMS National programme team in order to progress the implementation.

While the paper presents significant risk associated with the rapid implementation of the Citadel system, the direct comparison with the CliniSys offer, made the Citadel system implementation the least risky approach for NHS Fife.

2.3 Assessment

The core clinical and operation risk to NHS Fife is that if there is no implementation of the Citadel LIMS system within NHS Fife by April 2023, then the decommissioning of the LabCentre system (as indicated by the supplier), will result in significant operational

disruption caused by the inability to provide timely diagnosis of patients' conditions, resulting in the potential declaration of a Major Incident. (Datix Risk 2301).

The likelihood of having no LIMS system, at all, is assessed as being relatively small. What is more likely is that the system is available but hasn't reached a level of implementation for all disciplines. (e,g. Haematology/Biochemistry, Virology/Bacteriology, Pathology, Blood Transfusion, Point Of Care Testing Multi-Discipline).

As a result, the project is focussed on the large volume disciplines and those where no sustainable continuity plan exists. Options for continuity plans to include the NPEX system and the Blood Transfusion system are being considered.

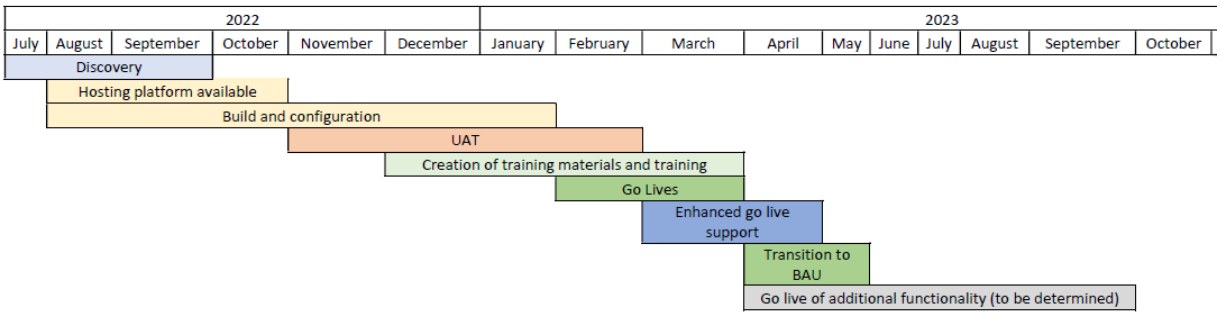
The primary mitigation to the overarching operational and clinical risk is the successful implementation of the Citadel system by March 2023.

The paper now looks to provide some background information on the project, the supplier commitment and key milestones. The focus turns to the identification of the key risks associated with the implementation project and the mitigations that are in place and in development to ensure these are managed and do not result in a delay to implementation. These risks will be managed within the project governance structure and form part of the continued reporting of the project.

The commitment made by Citadel is declared as: -

- This product will be operational to a minimum specification that allows the Health Boards to run their clinical services as an early phase with a go live date no later than 6th March 2023.
- Citadel Health will place a core system, harmonised where possible, and interfaced to the essential analysers and systems that are integrated to the LIMS in phase 1. Completion of interfacing to those not connected currently will happen in phase 2 or aligned to the wider Scottish programme.

The current milestone implementation plan is :-



While any project or system implementation will carry several inherent common risks, this paper outlines those key risks associated with the rapid deployment of the LIMS system.

The table below identifies these risks, their likely realisation timescale and details of mitigating and supporting actions.

Key Risks
Risk: The move to the Citadel system results in an increase to the scope of the implementation project and in particular the development of new interfacing to existing analysers. This scope adds additional activities to the project plan that will require resourcing and completion to meet the project timeline. **Risk Realisation:** This risk may materialise during the Build and Configuration and User Acceptance Testing phases of the project. The critical period for this risk is November 2022 to February 2023. **Mitigations:** The Labs team have a clear and identified set of priority services that would constitute a core deployment of the system. Those priorities will remain the area of focus and are receiving early attention in the project. Citadel have a significant number of interfaces already in use by customers and available in their "analyser library". A review of existing analysers in use within NHS Fife has concluded only a small number require additional interface build activity to be carried out. The potential of replacing the existing analysers maybe a consideration if interfacing is challenging. Additional interfacing expertise will be provided by the National Programme Team, other Consortium Boards and through 3rd Party Providers.
Risk: NHS Fife would need to ensure agreement on standard code sets and workflows. This also leads to the recognition of an increased scope of work for the project. The LIMS Consortium is trying to establish a unified approach to code sets and workflow. The risk is the complexity of achieving this as part of the national programme. **Risk Realisation:** This risk may materialise during the Build and Configuration and User Acceptance Testing phases of the project. The critical period for this risk is November 2022 to January 2023. **Mitigations:** The code set build and workflow configuration element has been progressing for several months within the national programme team and within NHS Fife. To date the timescales for completion for build and configuration date have been met. Shared ownership for defining build and configuration has been established so no single Board is required to complete all elements.

NHS Fife has membership within the National Consortium Programme Governance to support and ensure a reliable approach and key decision making is in place. The National Consortium recognises the risk associated with those Boards having to implement the Citadel system by March 2023 and is supporting the rapid implementation activities.

Risk: NHS Fife will need to ensure that key internal resource, primarily within Labs and Digital and Information are made available to focus on the implementation project. Any reduction in resource availability is likely to a delay in the implementation. Specific risk associated with the operational requirements and impact of winter for NHS Fife through the months of October to March 2023.

Risk Realisation: This risk may materialise at any stage during the project. However, the resource availability and the potential for most impact will be during the January 2023 to April 2023 period.

Mitigations:

NHS Fife Governance Committees and Executive Group are aware of the key importance of this project and activities are already being re-planned to ensure resources are consistently available for the implementation plan. Changes to the timescales for the TrakCare Mobile User Interface and Digital Pathology projects have already taken place.

The LIMS Business Case includes funding for backfill to ensure support is provided to business as usual and current operational activities, while key resources are protected to focus on the project.

Limited changes will be allowed to the current configuration of the LabCentre system and the wider Labs systems. This will reduce any unintended problems occurring that may need the specialist resources being diverted to resolve any problems.

The NHS Fife project will seek to utilise the regional, national and supplier's teams as much as possible during the implementation. Unifying around a single consortium build will enhance the efficiency of the resource utilisation for some phases of the project i.e. Build and Configuration and User Acceptance testing.

Senior Management will be providing direct and regular support to the project team and staff wellbeing will be a specific consideration during the project implementation period.

Risk: There is a requirement that strong governance and rapid decision making is available within NHS Fife, the National Consortium Programme team and the National Consortium Programme Board, to aid the speed of implementation.

Risk Realisation: This risk may materialise at any stage of the project but has the potential for most impact during the period of January 2023 and March 2023.

Risk Mitigation:

Local governance has been established within the core project team and through the Acute Senior Leadership Team.

The reporting mechanism to evidence progress against the milestone plan is in development and will be further enhanced with supplier meetings, planned for 27 October 2023.

NHS Fife has membership within the National Consortium Programme Governance to support and ensure an appropriate approach and key decision making is in place. The National Consortium is chaired by the current Chief Operating Officer for NHS Greater Glasgow and Clyde (a former Digital Lead).

NHS Fife will require to adopt a higher level of risk appetite associated with the implementation plan, given the rapid nature of the implementation. This will support additional decision-making being made within the project team than would otherwise be expected. Routes of escalation will be further developed and confirmed.

Risk: CliniSys may inflate their costs for maintenance of existing technologies or interfacing to those technologies as part of the project. These additional technologies include other system in use in Labs and the GP Order Comms System and any costs associated with interfacing to Citadel.

Risk Realisation: This risk may materialise at the early stages of the build and configuration and user acceptance testing phases of the project during the period of November 2022 and January 2023.

Risk Mitigation:

Additional coverage for implementation and potential uplift to costs has been included in the LIMS Business Case.

Early engagement with CliniSys and the project team have been positive. The work required by CliniSys has been specified and work is ongoing to confirm requirements and costs. The National Programme team are also supporting the engagement with CliniSys.

The additional technologies have different contractual arrangements to those associated with LabCentre and those contractual arrangements are under review.

The project team will continue to report fortnightly through the Acute and Digital SLTs and periodically to the Acute Services Division Clinical Governance Committee.

Additional progress reporting will be provided to EDG monthly. This reporting will include, for each phase in the milestone plan, the current progress achieved against target and associate risk and issue summary and management plans.

Following discussion, CGC may recommend additional consideration is given to the core operational and clinical risk.

CGC are asked to take assurance on the risk mitigations and reporting identified in this paper.

2.3.1 Quality/ Patient Care

The risk to Patient Care is outlined in the paper and forms the core consideration for this paper. Through the successful management of the project to the implementation of a "safe" LIMS system, the risk to patient care will be minimised.

By adopting the implementation of the National LIMS Consortium and Citadel system, NHS Fife, with Boards in the East Region, will develop a system that provides additional resilience and standard methods of operation that will support resilience with Labs reporting. This will materialise as other Boards adopt the solution.

2.3.2 Workforce

The impact to workforce is detailed within the paper. The project team and managers recognise the challenge which is placed on both Labs and Digital to ensure delivery. It will be imperative for us to work intensively with Citadel and the National Programme team to deliver at pace with active collaboration across the teams. The finalisation of the Business Case allows consideration to additional back fill staffing levels. As state in the risk mitigations, particular consideration will be given to staff wellbeing during this intensive period.

2.3.3 Financial

The financial impact has been detailed through the completed NHS Fife Full Business Case for LIMS. The management of finances will sit within the project team and with the support of Finance Business Partners.

2.3.4 Risk Assessment/Management

To deliver this system implementation at pace, EDG were asked to recognise the requirement to adopt a higher level of risk appetite associated with the rapid implementation. This will support additional decision-making being made within the project team than would otherwise be expected. Routes of escalation will be further developed and confirmed. This approach balances full quality controls across aspects of the system implementation against the clinical requirement to have a system implemented by March 2023.

Risks are outlined throughout the paper and will be further detailed as this work continues.

Risk Management and learning will be shared across the national network and will be enhanced by the implementation for NHS Western Isles and NHS Orkney who are planning to go live in February 2023.

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

An Equality Impact Assessment (Stage 1) form was completed to identify if any items of significance needed to be highlighted to the Committee. The outcome of that assessment concluded on Option 1: No further action required.

The project team, responsible for the implementation of the LIMS solution, will also conduct an Equality Impact Assessment specifically for the system implementation and operation.

2.3.6 Climate Emergency & Sustainability Impact

The procurement undertaken by the national consortium group followed the Sustainable Procurement Duty, which considered the impact on social, environmental and economic wellbeing.

2.3.7 Communication, involvement, engagement and consultation

Communication and engagement of this issue has included: -

- Previous submission of the Risk Assessment and SWOT analysis to EDG and NHS Fife's Board during August 2022.

2.3.8 Route to the Meeting

This paper was presented to:-

- EDG Meeting 20 October 2022

2.4 Recommendation

The Committee is asked to take assurance from the activities outlined within the paper.

- The Committee are asked to take assurance from the mitigation of the risks associated with the successful implementation to the Citadel system by March 2023.
- The Committee are asked to take assurance from the regular reporting to SLTs and EDG for the duration of the implementation period.

3 List of appendices

Nil

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Integrated Unscheduled Care Programme Update**
Responsible Executive:	**Dr Chris McKenna, Executive Medical Director**
Report Author:	**Fiona McLaren, Head of Corporate Programme Management Office**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on progress in relation to the Unscheduled Care Programme. It provides assurance that there is commitment and coordination across NHS Fife and Fife Health & Social Care Partnership.

2.2 Background

The Scottish Government relaunched the Urgent & Unscheduled Care National Collaborative on the 1 June 2022. As a result of this Fife were required to undertake a self-assessment to identify the highest impact changes for improvement. This process was undertaken collaboratively between NHS Fife and Fife Health & Social Care Partnership colleagues and identified the following areas for focus:

- Care Closer to Home
- Redesign of Urgent Care
- New Models of Acute Care
- Discharge without Delay

2.3 Assessment

Since July 2022 work has been underway within each high impact area to identify improvement work that meet the aims of the national programme 'Right Care, Right Place, Every time' and to prepare for Winter.

Each high impact change area has short life working groups established and there are change ideas either in the process of being tested or in the process of being planned. However due to the pressures on the system, improvement work has been extremely challenging.

In addition to the local work underway there is also an ongoing requirement to report and engage with the national programme. Weekly Sitreps are required highlighting performance against the 4-hour waiting standard. As well as there is a requirement to participate in monthly Learning Networks with other Health Board colleagues for each high impact change area. There is further support provided by a national improvement adviser and a regional lead from the national programme.

2.3.1 Quality / Patient Care

It is anticipated that the service provided in unscheduled care and the level of Patient Care will be improved through the revised programme of work.

2.3.2 Workforce

It is expected that this new programme will allow staff the opportunity to engage with new approaches to patient care. This should have a positive impact on staff wellbeing and morale if there are clear pathways and processes for them to follow to improve the patient journey.

2.3.3 Financial

The Integrated Unscheduled Care Programme Board are reviewing and monitoring any financial implications of the Programme. Any requests for additional money will be considered by the Integrated Unscheduled Care Programme Board.

2.3.4 Risk Assessment / Management

Risks for this work are identified and managed as part of the governance arrangements.

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

The Unscheduled Care Programme and its component projects seeks to reduce inequalities. Equality Impact Assessments were previously completed for Phase 2 of the Programme. The current Equality Impact Assessment is in the process of being refreshed to reflect the current phase of the Programme.

2.3.6 Climate Emergency & Sustainability Impact

Not used

2.3.7 Communication, involvement, engagement and consultation

As part of this work there is ongoing stakeholder mapping and engagement activities underway.

A local Winter Communications plan will commence from November 2022 which will actively engage with patients through various methods in support of 'Right Care, Right Place, Every time'. This will also reinforce the national messages which Scottish Government will deliver.

A Staff Engagement Plan is also being developed to ensure that staff are aware of the Programme and the work of the high impact change areas.

2.3.8 Route to the Meeting

This paper has already been considered by the Portfolio Board and the Integrated Unscheduled Care Programme Board.

2.4 Recommendation

This report is submitted for assurance and to provide an update on the work underway as part of the Unscheduled Care Programme.

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

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, USC September Programme Board Report V1.0

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Unscheduled Care

Programme	RAG
Care Closer to Home	A
Redesign of Urgent Care	A
New Models of Acute Care	A
Discharge without Delay	A

Senior Responsible Owner	Chris McKenna
Programme Manager	Fiona McLaren

Summary Status:

Summary of key activity completed

Overall Programme:

- Due to the extreme pressures on ED across the country an additional request was received from Scottish Government for improvement plans to be reviewed and aligned with the areas where they felt the most opportunistic areas were. This return has been submitted and feedback from Scottish Government is awaited. Additional work has been stepped up to look at the opportunistic areas to see what improvement work can be generated.
- The amber status reflects the challenge that exists in relation to the service pressures and the impact that this has in trying to plan and implement improvements.

Care Closer to Home:

- Currently there is one test of change running for SAS Respiratory pathway where patients known to Service can be treated at home rather than being brought to Hospital. So far only a small number of patients have come through this pathway.
- Plans are also being progressed to test an in hours Urgent Care Hub. Plans for the hub are currently being developed.

Redesign of Urgent Care:

- A review of the Flow Navigation Hub has been undertaken. As a result of that new pathways have been identified and will be prioritised for implementation.
- The test of change continues to triage and redirect patients to the minor injury's unit to QMH.
- A test of change is underway for SAS to call before they convey. This commenced on 28 September and to date 8 patients were not brought to the VHK ED.
- ED SLWG has been stood up to drive improvements within the department. Initial work has been looking at improvements to the minor's flow.
- Test of change involving a calling card with contact numbers being issued to SAS crews is showing an increased number of calls to FNH.

New Models of Acute Care:

- The test of change continues to review and prevent unplanned care patients being in planned care beds.
- A enhanced triage test of change is planned for October slightly delayed by the works required to the clinical unit.

Discharge without Delay

- Integrated Discharge Coordinator now in post (until 31st March 2023)
- Induction session with pathfinder wards held and Planned Discharge Dates (PDD) tests of change commenced. Captured learning from acute wards that manage discharges well to share with other wards.
- Community ward level stakeholder meetings now held monthly to provide ongoing support and peer support between wards and staff to build resilience and ensure sustainability.
- Medics have been consulted on how best to engage their peers on PDD and where challenges may arise

Summary of key activity over the next reporting period

Care Closer to Home:

- In hours Urgent Care Hub to be progressed.
- Communication and engagement work to commence.

Redesign of Urgent Care:

- FNH Pathways work to commence.
- Further improvement work around the ED to be taken forward.

New Models of Acute Care:

- Commence stage 2 of the virtual board round test of change and the links to Discharge without Delay.
- Commence enhanced triage test of change.

Discharge without Delay

- Internal communications PDD messaging to begin
- Additional support identified to drive forward PDD within community and acute wards as a ToC

Programme with upcoming milestones	Phase	Target Date	Forecast Date	RAG
Care Closer to Home				G
1. In-Hours Urgent Care Hub	Initiation	October 22	October 22	
2. GP MDT Resilience Team	Initiation	October 22	October 22	
3. SAS Pathways:				
1. Access to MIU's	Initiation	October 22	October 22	
2. Access to Social Care Crisis pathway		October 22	October 22	
4. Working with Localities to co-design services	Planning	November 22	November 22	
5. Communication Campaign – meet the team	Initiation	October 22	October 22	
Redesign of Urgent Care				G

1. MIU Test of Change round 2 2. Flow Navigation report completed 3. Pathway development 4. Communications	Implementation Implementation Initiation Implementation	Oct – Dec 22 September 22 Oct -Dec 22 Oct 22	Oct-Dec 22 September 22 Oct 22 Oct 22	
New Models of Acute Care 1. Virtual Board MDT test of change 2. Enhanced triage test of change 3. Ambulatory Care	 Implementation Initiation Initiation	 Aug – Oct 22 Oct – Nov 22 Aug – Oct 22	 Aug – Oct 22 Oct - Nov 22 Aug – Oct 22	G
Discharge without Delay • Plan created for wider improvement event • Engagement of acute pathfinder wards • Electronic recording of Planned Discharge Date (PDD) on Patientrack scoping work commenced	Implementation Implementation Initiation	October 22 October 22 tbc	October 22 October 22 tbc	G

Risks						Issues		
Likelihood	**Consequence**					**Issue No.**	**Issue**	**Mitigation**
	1 = Negligible	2 = Minor	3 = Moderate	4 = Major	5 = Extreme			
5 = Almost Certain		1						
4 = Likely		1		2	2			
3 = Possible								
2 = Unlikely								
1 = Remote								

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented for:

- Assurance

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 (with certain exceptions due to a lag in data availability) up to the end of August 2022.

2.2 Background

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

Improvement actions are included following finalisation of the Annual Delivery Plan for 2022/23, and this 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 Personal Development Plan & Review (PDPR), in the Staff Governance section. Further additions relating to Adverse Events (Clinical Governance) and Establishment Gap (Staff Governance) are expected to follow in due course.

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.

2.3 Assessment

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

The Clinical Governance aspects of the report cover HSMR, Falls, Pressure Ulcers, HAI and Complaints. A summary of the status of these is shown in the table below.
Performance is also reported for Adverse Events but measures that will enable assessment of performance are under development.

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

[1] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2022/23. These are a 10% reduction on the FY 2021/22 target for Falls, and a 25% reduction on the actual achievement in FY 2020/21 for Pressure Ulcers.

[2] Ongoing challenges relating to COVID and staffing levels within the Patient Relations Department has meant that closure performance of Stage 2 Complaints fell

significantly during FY 2021/22. An improvement target of 50% by March 2023, rising to 65% by March 2024 has been agreed by the Director of Nursing.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

A mapping of key Corporate Risks to measures within the IPQR is provided via a Risk Summary Table, the Indicator Summary Table, the Executive Summary narratives and the relevant drill-downs.

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 October IPQR will be available for discussion at the meeting on 4 November.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 20 October and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The report is being presented to the CG Committee for:

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

3 List of appendices

- Integrated Performance & Quality Report

Report Contact
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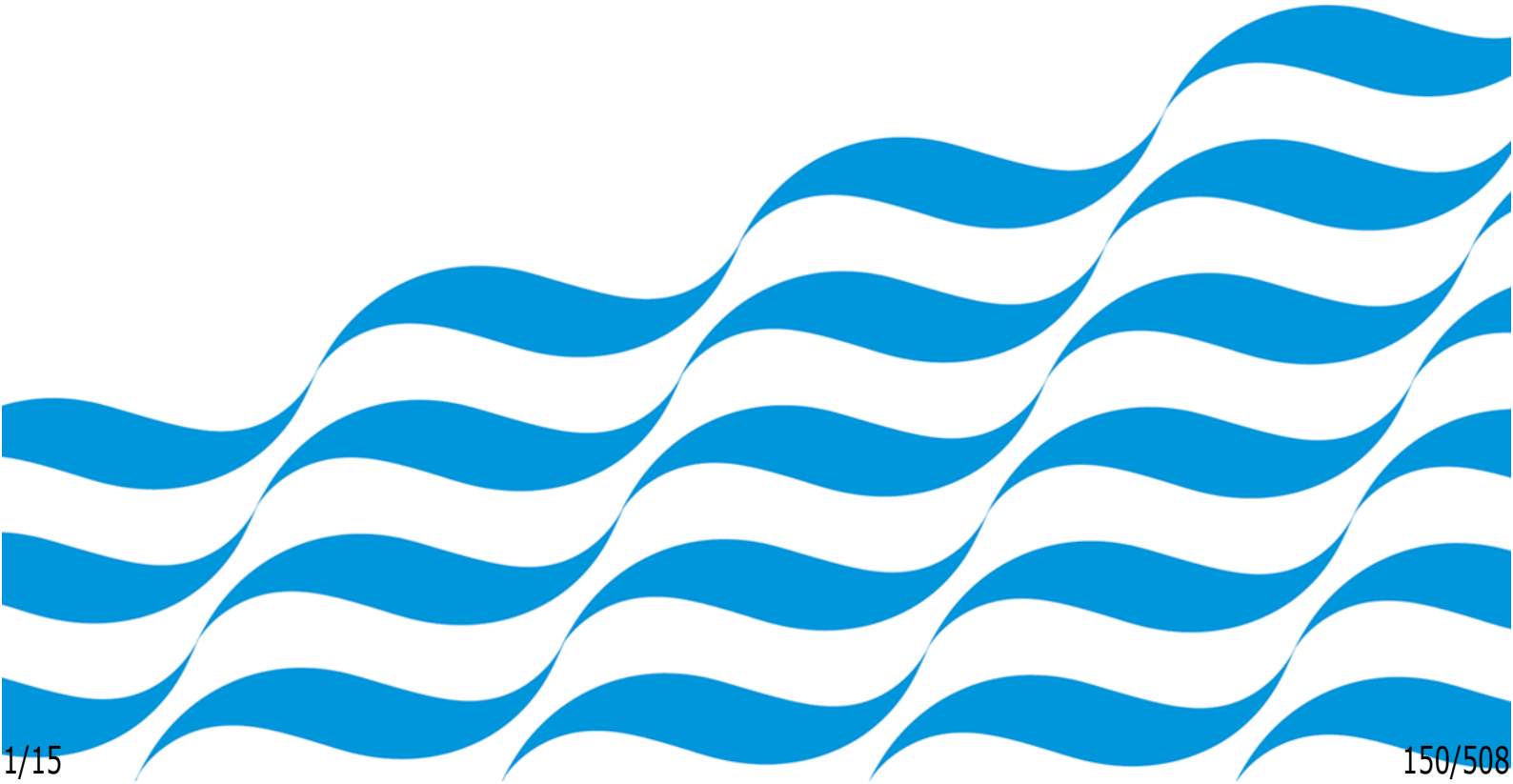
Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Produced in October 2022



Introduction

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

Amendments have been made to the IPQR following the IPQR Review. This involves 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** ****NEW****
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 are also columns indicating where a measure is related to a key Corporate Risk and 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
18 October 2022

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

a. Corporate Risk Summary

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	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**	◀ ▶	Moderate

Summary Statement on Risk Profile

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

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

Assessment of corporate risk performance and improvement trajectory is 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	N/A	Month	Aug-22	29	○	▲	▲	●	
	HSMR	N/A	Year Ending	Mar-22	1.02	●	◀▶	◀▶	●	
	Inpatient Falls	6.91	Month	Aug-22	6.45	○	▲	▲	●	
	Inpatient Falls with Harm	1.65	Month	Aug-22	1.69	○	▼	▼	●	
	Pressure Ulcers	0.89	Month	Aug-22	1.03	○	▼	▲	●	
	SAB - HAI/HCAI	18.8	Month	Aug-22	10.0	○	▲	▲	●	QE Jun-22
	C Diff - HAI/HCAI	6.5	Month	Aug-22	10.0	○	▲	▲	●	QE Jun-22
	ECB - HAI/HCAI	33.0	Month	Aug-22	33.2	○	▲	▲	●	QE Jun-22
	Complaints Closed - Stage 1	80%	Month	Aug-22	73.1%	○	▲	▲	●	2020/21
	Complaints Closed - Stage 2	50%	Month	Aug-22	8.9%	○	▲	▼	●	2020/21
Operational Performance	IVF Treatment Waiting Times	90%	Month	Aug-22	100.0%	●	◀▶	◀▶		
	4-Hour Emergency Access	95%	Month	Aug-22	68.4%	○	▼	▼	●	Aug-22
	Patient TTG % <= 12 Weeks	100%	Month	Aug-22	51.4%	●	▼	▼	●	Jun-22
	New Outpatients % <= 12 Weeks	95%	Month	Aug-22	52.9%	●	▼	▼	●	Jun-22
	Diagnostics % <= 6 Weeks	100%	Month	Aug-22	65.9%	●	▲	▼	●	Jun-22
	18 Weeks RTT	90%	Month	Aug-22	73.6%	●	▲	▲	●	QE Jun-22
	Cancer 31-Day DTT	95%	Month	Aug-22	98.5%	○	▼	▼	●	QE Jun-22
	Cancer 62-Day RTT	95%	Month	Aug-22	84.7%	○	▼	▼	●	QE Jun-22
	Detect Cancer Early	29%	Year Ending	Dec-21	23.9%	●	▲	▲	●	2020, 2021
	Freedom of Information Requests	85%	Month	Aug-22	83.1%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Aug-22	11.9%	●	◀▶	▲	●	QE Jun-22
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Aug-22	7.7%	○	▼	▲	●	QE Jun-22
	Antenatal Access	80%	Month	Jun-22	81.0%	●	▼	▼	●	CY 2021
Finance	Revenue Resource Limit Performance	(£10.4m)	Month	Aug-22	(£14.7m)	●	▼	—	●	
	Capital Resource Limit Performance	£33.1m	Month	Aug-22	£11.5m	●	—	—	●	
Staff Governance	Sickness Absence	4.00%	Month	Aug-22	6.50%	○	▼	▼	●	YE Mar-22
	Personal Development Plan & Review (PDPR)	80%	Month	Sep-22	33.3%	●	▲	—	●	
Public Health & Wellbeing	Smoking Cessation (FY 2022/23)	473	YTD	May-22	42	●	—	▼	●	QE Dec-21
	CAMHS Waiting Times	90%	Month	Aug-22	73.0%	○	▲	▼	●	QE Jun-22
	Psychological Therapies Waiting Times	90%	Month	Aug-22	68.4%	○	▼	▼	●	QE Jun-22
	Drugs & Alcohol Waiting Times	90%	Month	Jun-22	94.3%	●	▲	▲	●	QE Jun-22
	COVID Vaccination (Autumn/Winter Booster, Age 65+)	80%	Month	Sep-22	30.1%	●	▲	—	●	
	Flu Vaccination (Age 65+)	80%	Month	Sep-22	30.1%	●	▲	—	●	
	Immunisation: 6-in-1 at Age 12 Months	95%	Quarter	Jun-22	95.2%	○	▲	▲	●	QE Jun-22
	Immunisation: MMR2 at 5 Years	92%	Quarter	Jun-22	89.9%	○	▲	▲	●	QE Jun-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	Month End			Quarter End	Quarter End	Quarter End
		Jun-22	Jul-22	Aug-22	Sep-22	Sep-22	Dec-22	Mar-23
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	3,036	1,012	1,012	1,029	3,053	3,087	3,087
	Actual	2,878	885	1,046	1,063	2,994	0	0
	Variance	-158	-127	34	34	-59		
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	18,567	6,201	6,220	6,385	18,806	19,132	19,166
	Actual	20,951	6,291	7,832	7,301	21,424	0	0
	Variance	2,384	90	1,612	916	2,618		
Urgent	Actual	10,868	3,477	4,169	3,717	11,363	0	0
Routine	Actual	10,083	2,814	3,663	3,584	10,061	0	0
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,491	497	497	497	1,491	1,491	1,491
	Actual	1,550	477	617	503	1,597	0	0
	Variance	59	-20	120	6	106		
Upper Endoscopy	Actual	575	184	243	199	626	0	0
Lower Endoscopy	Actual	182	46	82	61	189	0	0
Colonscopy	Actual	738	234	269	234	737	0	0
Cystoscopy	Actual	55	13	23	9	45	0	0
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	11,988	3,996	3,996	3,996	11,988	11,988	11,988
	Actual	13,471	4,350	4,593	3,993	12,936	0	0
	Variance	1,483	354	597	-3	948		
CT Scan	Actual	4,083	1,322	1,379	1,288	3,989	0	0
MRI	Actual	2,936	979	1,109	835	2,923	0	0
Non-obstetric Ultrasound	Actual	6,452	2,049	2,105	1,870	6,024	0	0

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services

5

5	-	-	-

		Target	Current
HSMR		**1.00**	**1.02**

Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife.

Inpatient Falls	*Reduce all patient falls rate by 10% in FY 2022/23 compared to the target for FY 2021/22*	**6.91**	**6.45**

The slow downward trend in all falls across NHS Fife in patient areas continues. This current rate compares with 7.93 OBD at the same time last year. Of the total number of falls (187) in August 138 had no harm, 41 minor harm, 3 moderate harm and 5 major or extreme - every fall is reviewed locally through a local adverse event process.

An improvement plan is in place in ASD, in the areas where the highest number of falls with harm are noted. This plan covers a range of approaches and will focus on education, audit and review of local data for improvement. The HSCP group has been refreshed to focus on the 32 wards in community hospitals. Of note a piece of improvement work within Mental Health has resulted in a sustained reduction in falls. This has been a true MDT (AHP, Pharmacy etc) approach proactively reviewing those patients at high risk of falls.

Learning from this work is being shared more broadly across the H&SCP and the ASD. Within in-patient settings local data is displayed and discussed with teams and work is ongoing to ensure there is a link practitioner in each in-patient setting - H&SC have achieved this and this ties in with the plan to have a wider practitioner (previously known as champion) network.

Challenges do however continue with both pressures on capacity and workforce challenges and noting the need to focus on the environmental context particularly in older estate to mitigate where possible to support this work.

Pressure Ulcers	*Reduce pressure ulcer rate by 25% in FY 2022/23 compared to the rate in FY 2021/22*	**0.89**	**1.03**

The data for Hospital Acquired Pressure Ulcer incidents (all grades) across NHS Fife as a whole, continues to show an unchanged picture, with random variation noted.

The “Pressure Ulcer Report” which is published each month is shared with clinical teams and discussed and reviewed at the Tissue Viability Steering Group. Ongoing initiatives continue to support learning and improvement, with the aim of reducing the incidence of pressure ulcers; the Acute Services Division launched the “newly tested” documentation tool on 5th October, which incorporates a section on pressure ulcers, and an e-version of the PURA and SSKIN bundles which supports robust assessment and care management is currently being developed on Patientrak.

Clinical teams are encouraged to take ownership of their own data and improvement activities by sharing outcomes data with their teams.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**18.8**	**10.0**

NHS Fife continues to address its SABs and is currently ahead of the trajectory to achieve the 10% reduction by March 2023. In 2022 to date, 4 PICC Line associated SABs have been identified (1 of which was a relapse of infection) and 6 PWID SABs. Positively, following a single PVC SAB in March, there have been no further PVC related SABs and no Renal haemodialysis line related SABs this year.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**6.5**	**10.0**

NHS Fife is above the trajectory for CDI to achieve the 10% reduction target by March 2023, although we are below the national average. There have been 20 health care associated CDI to date in 2022. Reducing the incidence of CDI recurrence is pivotal to achieving the HCAI reduction target and continues to be addressed. There have been only 3 recurrences of infection in 2022.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2023*	**33.0**	**33.2**

NHS Fife is marginally above the target to achieve the ambitious 25% reduction of HCAI ECBs by March 2023. Reducing CAUTI HCAI ECB incidence remains the quality improvement focus to achieve our targets, there have been 21 CAUTIs in 2022 to date. Enhanced surveillance is in place aiming to identify other areas for quality

		Target	Current
improvement.			
Complaints – Stage 2	*At least 50% of Stage 2 complaints will be completed within 20 working days by March 2023, rising to 65% by March 2024*	**50%**	**8.9%**

Investigating and responding to Stage 2 complaints within the national timescales remains challenging, primarily due to staffing and capacity issues across all services. We also continue to see an increased volume of complex complaints, covering multiple specialities/services.

The previous backlog of complaint responses has been cleared and the overall number of 'live' complaints has been reduced, as result of streamlining processes and realigning workloads. An analysis of delays has revealed 40% of complaints are awaiting statements to be provided. As the majority of complaints currently within the 20-day target are still awaiting statements, the risk of not achieving more than a 10% response rate remains high.

Within the Patient Experience Team, capacity and staffing challenges are exacerbated by vacancies and absence. A Support Officer post is being recruited, while there is one staff member on a bank contract. Additional support from redeployed members of the Test and Protect team ceased at the end of September.

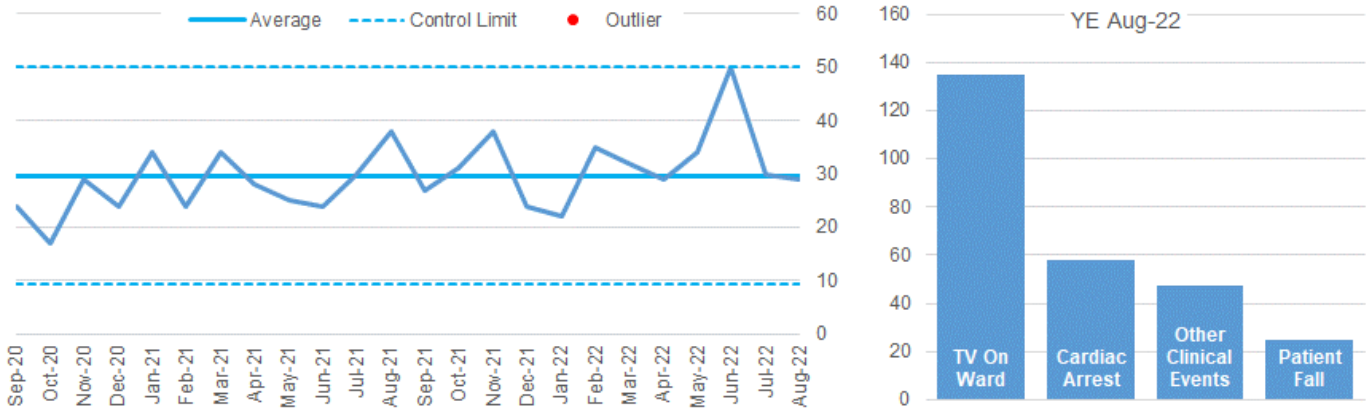
With the additional support and change in processes, the number of complaints being drafted or awaiting drafting has dropped significantly to 7%.

However, the number of delayed complaints within the system continues to have a negative impact, due to the increased workload on staff (managing multiple caseloads).

e. Performance Exception Reports

Adverse Events	Performance 29

Major and Extreme Adverse Events



All Adverse Events

		2021/22							2022/23				
		SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
ALL	NHS Fife	1401	1398	1440	1494	1501	1299	1471	1239	1408	1312	1324	1322
	Acute Services	612	650	631	594	613	514	674	529	610	600	619	591
	HSCP	747	692	750	836	853	734	730	657	750	665	684	684
	Corporate	42	56	59	64	35	51	67	53	48	47	21	47
CLINICAL	NHS Fife	968	953	1016	968	942	905	1059	853	1013	924	858	907
	Acute Services	539	570	580	533	566	464	614	481	546	529	529	540
	HSCP	402	353	407	394	361	411	406	350	445	371	323	351
	Corporate	27	30	29	41	15	30	39	22	22	24	6	16

Commentary

The total number of adverse events in August was lower than monthly average for the previous 11 months. The number of major and extreme events was also lower in July and August,

There has been an increase in the number of events within the 'Access/Appointment/Admission/Transfer or Discharge' category, with 45 events compared to a monthly average of 34. Although numbers had dropped in July this reduction has been reversed with more events in August than any month in the previous year. This data will be kept under review and brought to the attention of the appropriate clinical governance group if the trend persists.

Cardiac Arrest events previously increased in May and June followed by a decrease in July (still at that point sitting above average compared to the preceding 10 months). Data shows that this reduction has continued into August. The Deteriorating Patient Group has presented a detailed review of the number of cardiac arrests to the Clinical Governance Oversight Group and improvement actions have been agreed.

A decrease is also noted in the number of Patient Falls' continuing a month-on-month reduction since May with 191 cases compared to an average of 217 for the previous 11 months – early indications however show that figures have increased in September. This data is reviewed on a monthly basis in the falls audit report and is reported to the Inpatient Falls Steering Group.

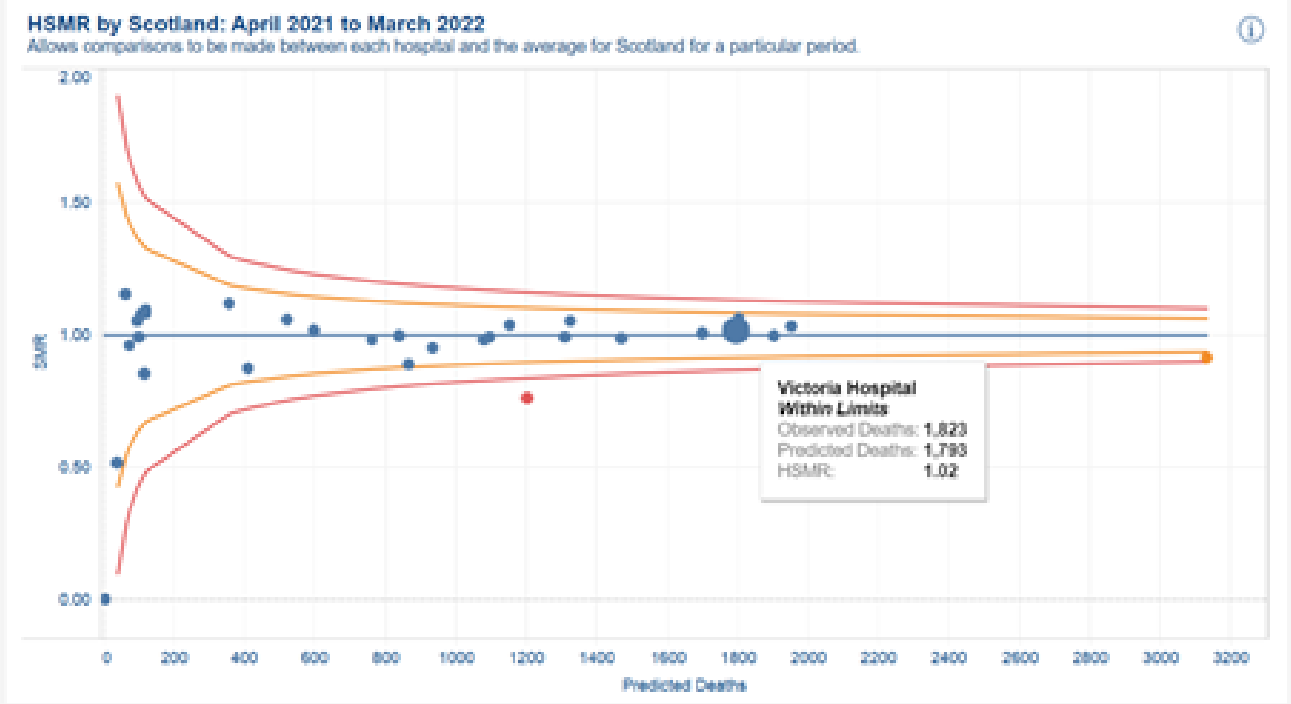
Key Deliverable	End Date
Adverse Event Process and Policy Review including 1) Review of policy 2) Increased focus on governance/assurance in relation to improvement actions from adverse events 3) training and education	Mar-23 On track

HSMR *Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.*	Performance 1.02

Reporting Period; April 2021 to March 2022[p]

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

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



Commentary

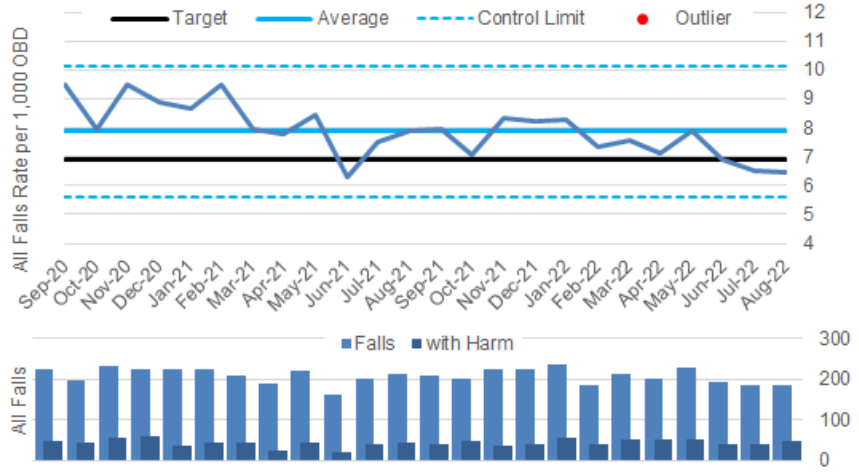
Data for 2021 and Q1 of 2022 demonstrates a return to a typical ratio for NHS Fife.

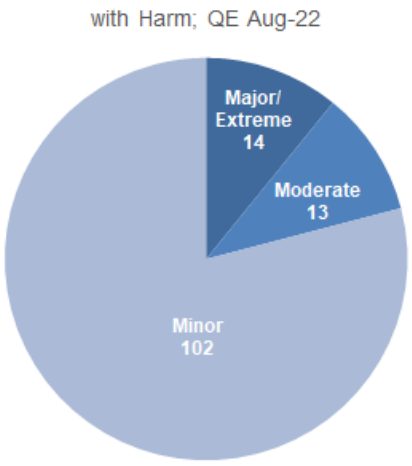
Inpatient Falls

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

Performance 6.45

Local Performance





Performance by Service Area

	2021/22							2022/23				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	7.93	7.08	8.32	8.25	8.29	7.33	7.59	7.13	7.90	6.91	6.51	6.45
Acute Services	7.61	8.51	8.71	8.47	9.39	7.55	7.10	8.25	8.11	7.83	8.20	6.67
HSCP	8.21	5.85	7.97	8.06	7.34	7.16	8.01	6.14	7.72	6.08	4.97	6.25

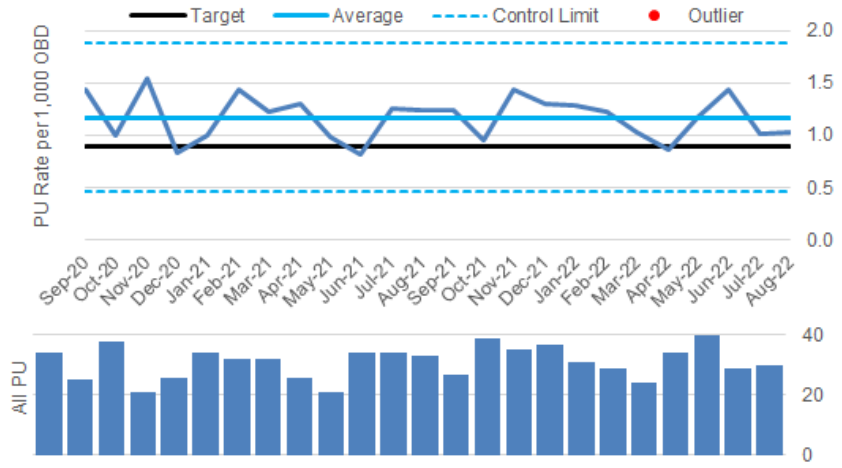
Key Deliverable		End Date
Reduction in number of Patient Falls in order to achieve specified reduction target in this FY		Mar-23 On track
Key Milestones	Refresh Falls Champions Register and Network	Oct-22 On track
	Ensure that monthly falls data continues to be discussed and displayed in each ward setting along with associated improvement plans	Mar-23 On track
	Develop an Audit programme for 2022/23	Jun-22 Complete
	Review and refresh Falls Toolkit	Apr-23 On track
	Review Related policies- Supervision, Boarding and Bed rails as identified/required by the policy timescales	Apr-23 On track
	Review LEARN summaries to support shared learning	Mar-23 On track
	Explore feasibility of implementation of Falls module on Patient Trak	Mar-23 On track
	Explore QI resource to support clinical staff and enhance local improvement work	Oct-22 Not started

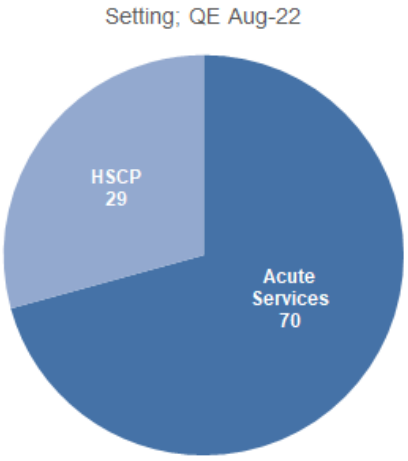
Pressure Ulcers

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

Performance 1.03

Local Performance





Performance by Service Area

	2021/22							2022/23				
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	1.24	0.95	1.44	1.30	1.29	1.23	1.03	0.87	1.18	1.44	1.02	1.03
Acute Services	2.10	1.44	2.54	2.16	2.18	1.84	1.76	1.37	1.77	2.13	1.48	1.61
HSCP	0.49	0.53	0.49	0.55	0.52	0.72	0.40	0.41	0.66	0.82	0.60	0.52

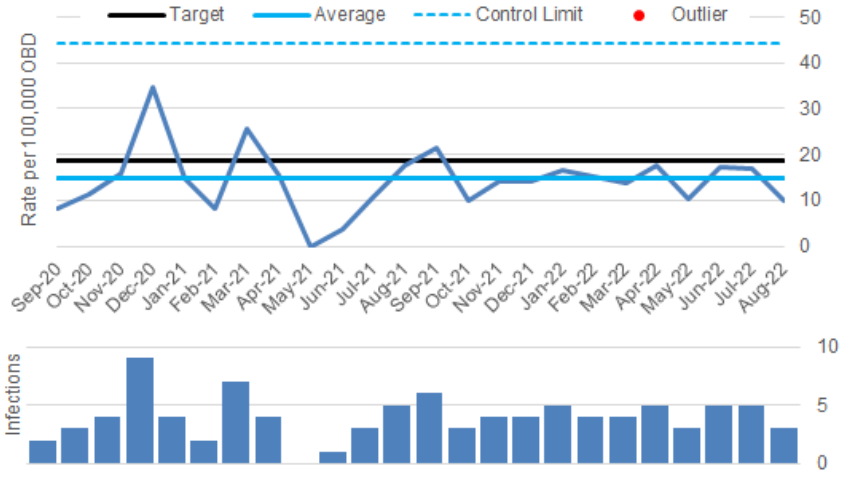
Key Deliverable		End Date
Reduction in number of Pressure Ulcers (PU) developed on case load across all health care setting in order to achieve specified reduction target in this FY *Data continues to show a random pattern*		Mar-23 Off track
Key Milestones	Refresh PU Link Practitioner Register and Network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

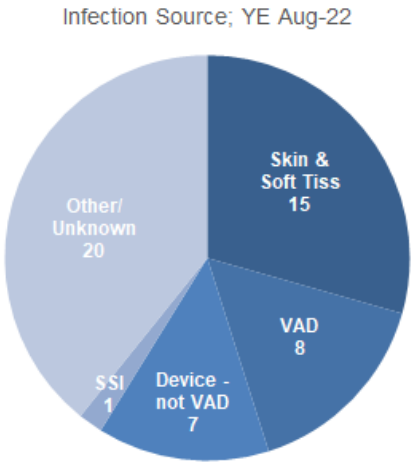
SAB (HAI/HCAI)

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

Performance 10.0

Local Performance





National Benchmarking

Quarter Ending	2020/21		2021/22				2022/23
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	20.6	17.8	6.3	16.6	12.7	15.2	14.9
Scotland	18.9	18.4	18.6	18.3	17.3	16.3	17.3

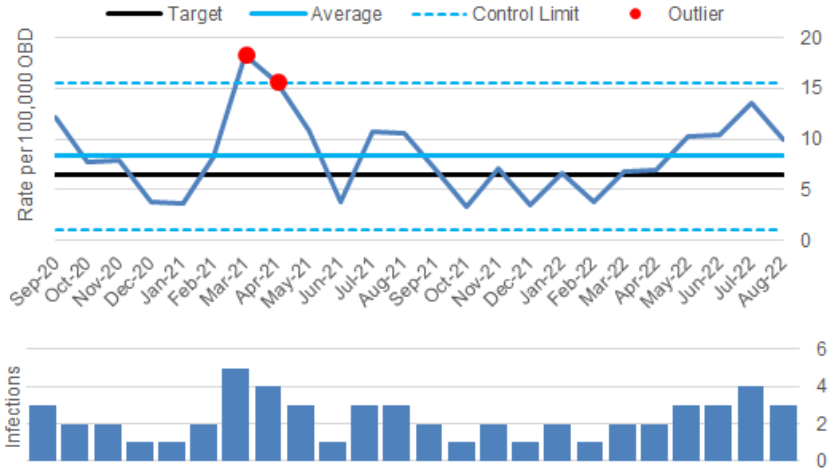
Key Deliverable	End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement Optimise communications with all clinical teams in ASD & the HSCP	Mar-23 On track
Programme of audit;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

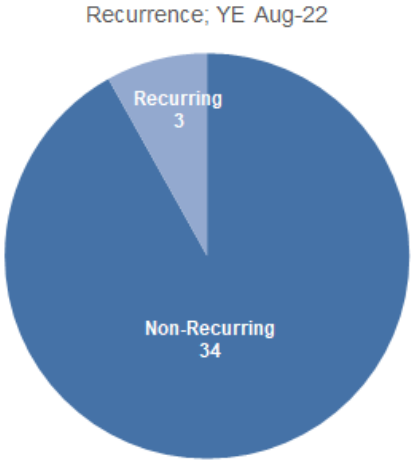
C Diff (HAI/HCAI)

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

Performance 10.0

Local Performance





National Benchmarking

Quarter Ending	2020/21		2021/22				2022/23
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	7.7	14.0	10.0	9.5	4.6	7.0	9.2
Scotland	16.4	15.8	14.6	16.8	13.3	12.6	14.3

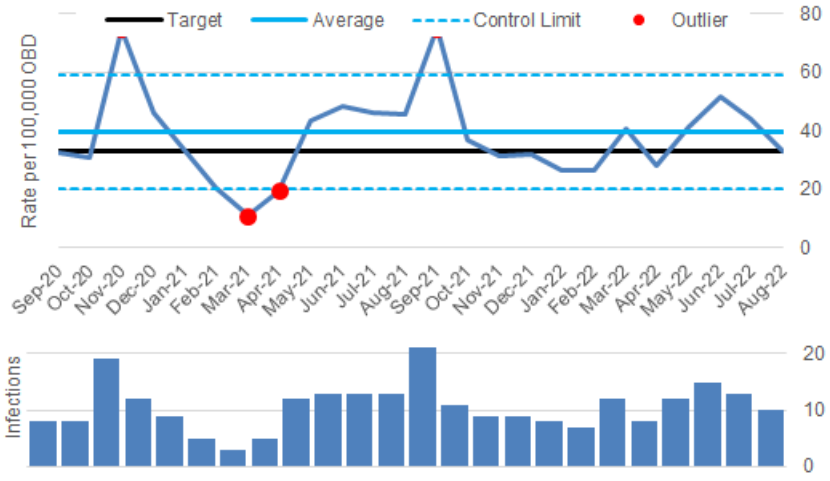
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23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

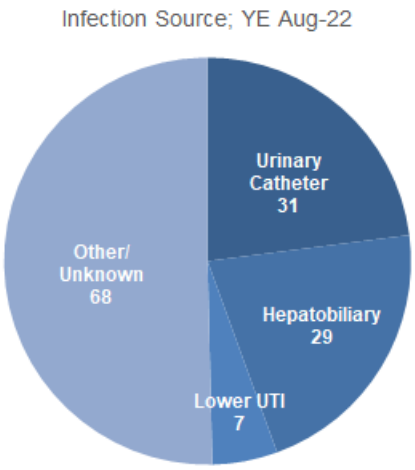
ECB (HAI/HCAI)

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

Performance 33.2

Local Performance





National Benchmarking

Quarter Ending	2020/21		2021/22				2022/23
	Dec	Mar	Jun	Sep	Dec	Mar	Jun
NHS Fife	50.3	21.6	37.6	60.3	33.6	31.6	40.2
Scotland	40.9	34.7	38.2	41.5	34.1	30.5	34.8

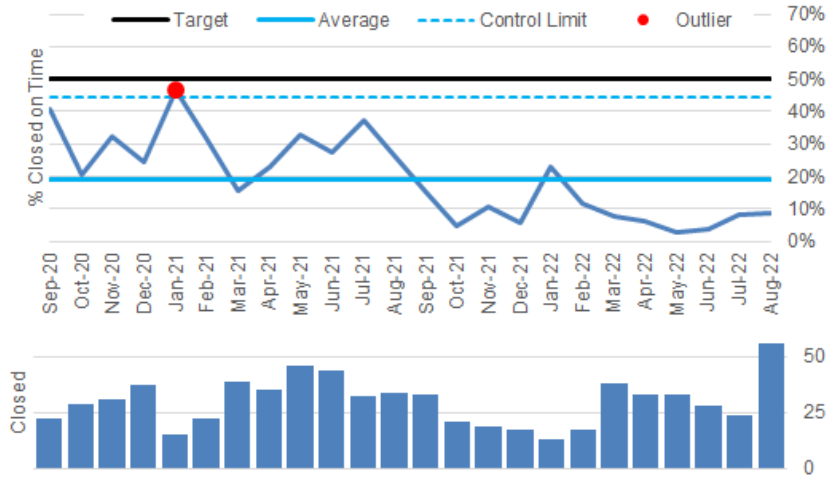
Key Deliverable		End Date
Local and national programme of surveillance; to undertake surveillance programmes which are compliant with mandatory national requirements and identify areas for improvement		Mar-23 On track
Key Milestones	Optimise communications with all clinical teams in ASD & the HSCP	Mar-23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

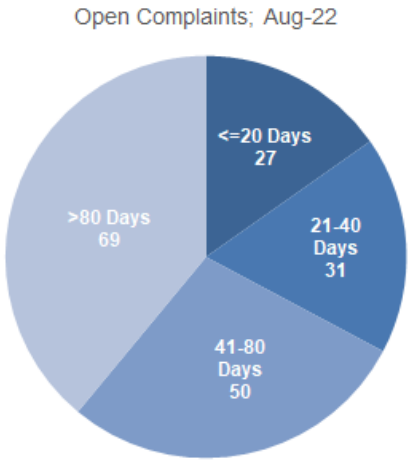
Complaints | Stage 2

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

Performance 8.9%

Local Performance





Performance by Service Area

		2021/22							2022/23				
		SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
NHS Fife	% Closed on Time	15.2%	4.8%	10.5%	5.9%	23.1%	11.8%	7.9%	6.1%	3.0%	3.6%	8.3%	8.9%
	% Acknowledged (3 days)	100.0%	100.0%	100.0%	88.2%	84.6%	100.0%	89.5%	87.9%	90.9%	96.4%	83.3%	76.8%
Acute Services	% Closed on Time	21.7%	0.0%	16.7%	7.7%	30.0%	18.2%	3.6%	8.0%	0.0%	5.0%	14.3%	4.3%
HSCP	% Closed on Time	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	9.1%	0.0%	0.0%	25.0%

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for October 2022 committee to provide assurance that all IP&C priorities are being and will be delivered.

This is presented for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

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

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

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

***Staphylococcus aureus* Bacteraemia SAB**

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

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

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

2.3 Assessment

SAB

- During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for healthcare associated infection (HCAI) and above for community associated infection (CAI).
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.
- There have been 6 PWID SABs during the time period January-August 2022

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. Next meeting planned 17/10/2022.

CDI

- During Q1 2022 (Jan-Mar), NHS Fife was below the national rate for HCAI & CAI.
- The cumulative total of CDIs from Jan-August 2022 (28 cases) is lower than during the same time period in 2021, when there were 35 cases.

Current CDI initiatives

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

ECB

- During Q1 2022 (Jan-Mar), NHS Fife was above the national rate for HCAI & CAI.
- Considering the time period Jan-August 2022, the number of ECBs (188 cases) has risen, compared to the same time period the previous year (Jan-August 2021), when there were 160 ECBs.

Current ECB Initiatives

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

COVID-19 pandemic

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

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

Surgical Site Infection (SSI) Surveillance Programme

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

Caesarean Section SSI

Local SSI surveillance is being undertaken by the midwifery team to provide local

assurance. The surveillance team are in communication with the team & supporting this work.

Large Bowel Surgery SSI and Orthopaedic Surgery SSI

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

Outbreaks (July – August 2022)

- **Norovirus**

There has been **no** new ward closure due to a Norovirus outbreak

- **Seasonal Influenza**

There has been NO new closures due to confirmed Influenza

- **COVID-19**

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

Hospital Inspection Team

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

Hand Hygiene

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

Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 4 (Jan - March 2022) was **96.2%**.

National Cleaning Services Specification

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

Estates Monitoring

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

2.3.1 Quality/ Patient Care

Effective infection prevention and control are essential to the delivery of high quality patient care and to the provision of a clean and safe environment for patients, visitors and other service users.

2.3.2 Workforce

Effective infection prevention and control are essential to the provision of a clean and safe working environment, and to overall staff health and wellbeing.

2.3.3 Financial

No financial costs identified in this report.

2.3.4 Risk Assessment/Management

Challenges and management of any risks to national infection prevention and control guidance discussed throughout report

2.3.5 Equality and Diversity, including health inequalities 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 October 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- HAIRT Report

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 5th October 2022.

(Validated Data up to August 2022)

October 2022

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

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

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

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

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

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

1.2 Challenges:

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

SABs

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

There have been 6 PWID SABs during the time period January-August 2022. This is a higher number of cases than during the whole of 2021 (January-December 2021). IPCT continue to liaise with the Addictions Service and the next meeting is due to take place on 17th October 2022.

ECBs

Considering the time-period Jan-Aug 2022, the number of ECBs (188 cases) has risen, compared to the same timeframe the previous year (Jan-Aug 2021), when there were 160 ECBs. The number of HCAI (HAI + HCAI) cases has also risen during Jan-Aug 2022 (85 cases), in comparison to Jan-Aug 2021 when there were 77 cases.

CDI

The cumulative total of CDIs from Jan-Aug 2022 (28 cases) is significantly lower than during the same time-period in 2021, when there were 35 cases. This improvement is also reflected in the number of Healthcare associated (HAI + HCAI + Unknown) CDIs; in Jan-Aug 2022 there were 20 cases, compared to 22 in Jan-June 2021.

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

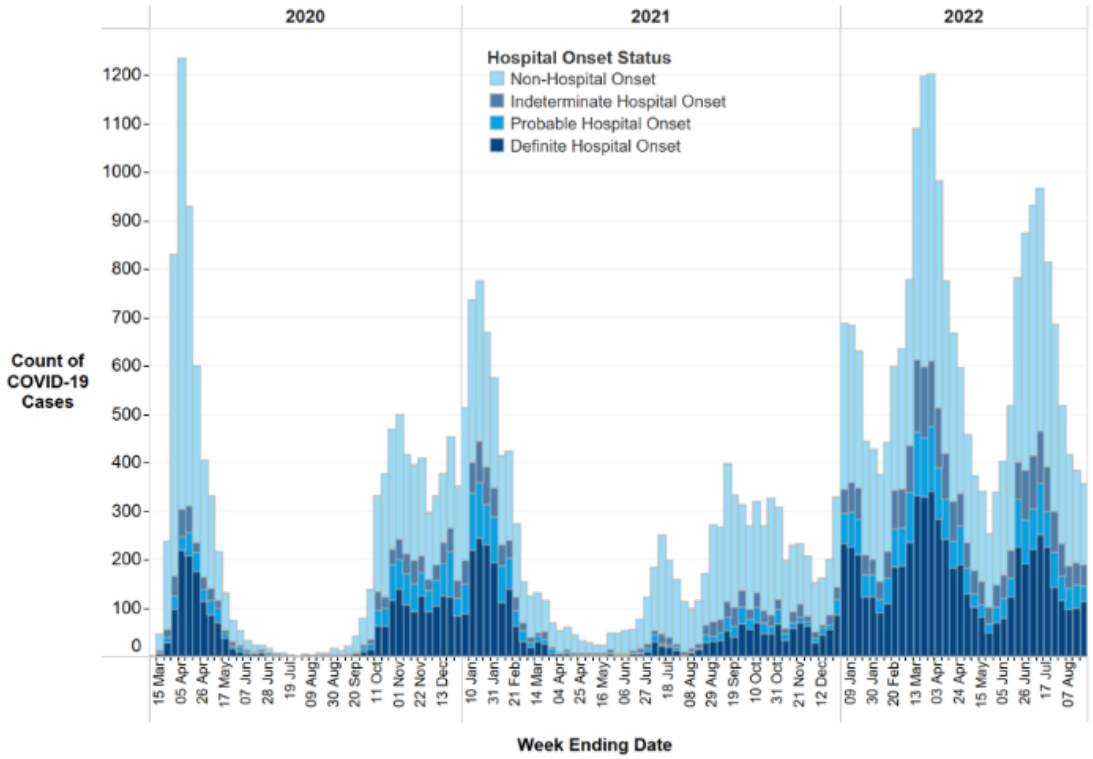
National surveillance programme for SSI 2021/22 has been paused due to the COVID-19 pandemic. However, a DL (2022) 13, published on the 11th May 2022 stated that resumption of the surveillance was due to commence in Q4 2022. Since then there has been a further delay, and the current situation is to aim to resume in Q2 2023. Much preparation and extra resources will be required prior to this taking place.

COVID-19

The Scottish Government Test and Protect Transition Plan set out changes to testing, that came into effect in May 2022 (further changes to be implemented 29/09/2022), with testing only remaining in place for certain groups to protect high risk settings and support clinical care.

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

Figure 1: Epidemic curve of COVID-19 cases with first positive specimen of COVID-19 episode taken during an inpatient stay, by onset status: week-ending 01 March 2020 to week-ending 21 August 2022 (n=43,562). [1,2]

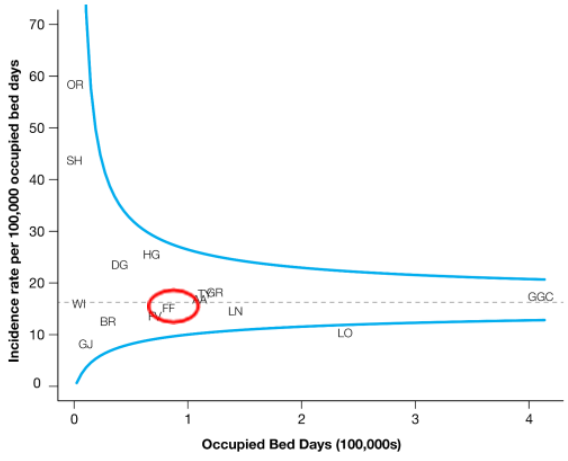
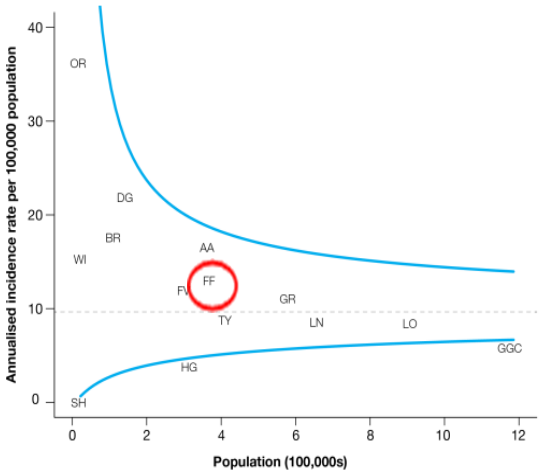


Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q2 2022 (April - June) **(Q2 2022 National comparison awaited)**				
In Q2 2022 NHS Fife had:	23 SABs	13 HCAI/HAI 10 CAI	This is **THE SAME** as:	23 Cases in Q1 2022

Q1 2022 (Jan-Mar) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **15.2**	Per 100,000 bed days	CAI SABs rate: **13.0**	Per 100,000 Pop
No of HCAI SABs: 13		No of CAI SABs: 12	
This is **BELOW** National rate of 16.3		This is **ABOVE** National rate of 9.6	
			
NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis for HCAI & CAI.			

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline). This standard will be extended by one year to 2023			
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2022**	**SAB 10% reduction target maintenance by 2023**
SAB by rate 100,000 Total bed days	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**	**68**
Current 12 Monthly HCAI SAB rates for Year ending March 2022 (HPS)			
SAB by rate 100,000 Total bed days	**12.8** per 100,000 TBDs		
SAB by Number of HCAI cases	**43**		

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have no further dialysis line related SABs since the most recent case on 15/10/21. The IPCT continues ongoing surveillance and provides support to the renal staff around VAD care.

As of **12/09/2022** the number of days since the last confirmed SAB is as follows:	
CVC SABs	49 Days
PWID (IVDU)	20 Days
Renal Services Dialysis Line SABs	332 Days
Acute services PVC (Peripheral venous cannula) SABs	179 Days

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

2.2 Current SAB Initiatives

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

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

- Use results locally for prioritising resources.
- Use data to inform clinical practice improvements thereby improving the quality of patient care.
- Liaise with Drug addiction services re PWID (IVDU) SABs. The most recent meeting took place on 23/5/22; some progress has been made with the PGDs and they should be available soon and the refresher training video will be re-shared with staff. The next meeting is planned for 17th October 2022.

2.3 National MRSA & CPE screening programme

MRSA

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

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

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

It was **ABOVE** the national average of 80%

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

Quarter	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun
Fife	98%	88%	98%	95%	98%	88%	93%	98%	98%
Scotland	87%	86%	82%	83%	84%	81%	82%	81%	80%

CPE (Carbapenemase Producing Enterobacteriaceae)

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

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

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

It was **ABOVE** the national average of 79%

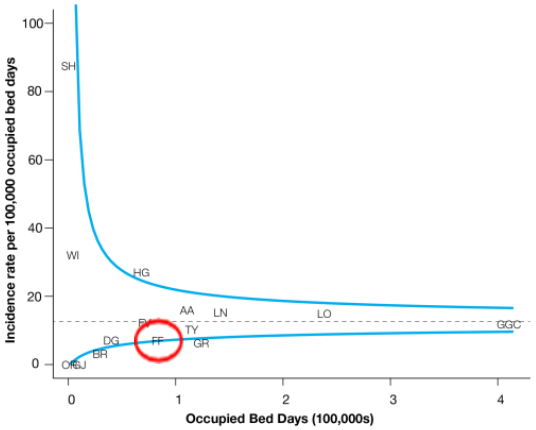
Quarter	Q2 2020 Apr-Jun	Q3 2020 Jul-Sept	Q4 2020 Oct-Dec	Q1 2021 Jan-Mar	Q2 2021 Apr-Jun	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	Q1 2022 Jan-Mar	Q2 2022 Apr- Jun
Fife	95%	85%	98%	88%	90%	100%	98%	100%	98%
Scotland	80%	85%	79%	82%	83%	82%	80%	80%	79%

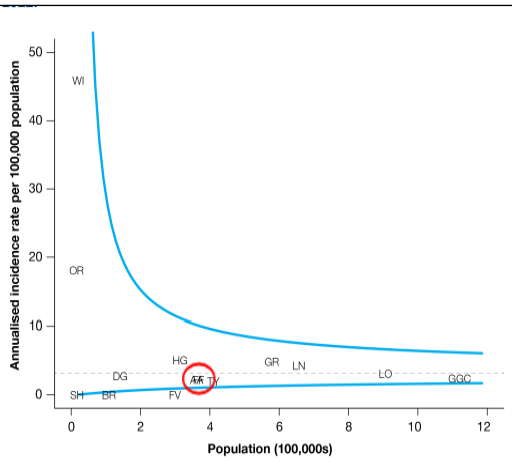
3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q2 Apr-Jun 2022 **(Q2 2022 HPS National comparison awaited)**				
In Q2 2022 NHS Fife had:	12 CDIs	8 HCAI/HAI/Unknown 4 CAI	This is **UP** from	7 Cases in Q1 2022
Q1 (Jan-Mar) 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: **7.0**	Per 100,000 bed days	CAI CDIs rate: **2.2**	Per 100,000 Pop
No of HCAI CDIs: 6		No of CAI CDIs: 2	
This is **BELOW** National rate of 12.6		This is **BELOW** National rate of 3.2	





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

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

3.2 Current CDI initiatives

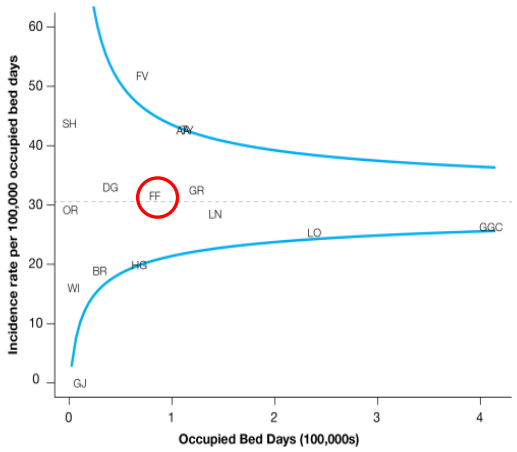
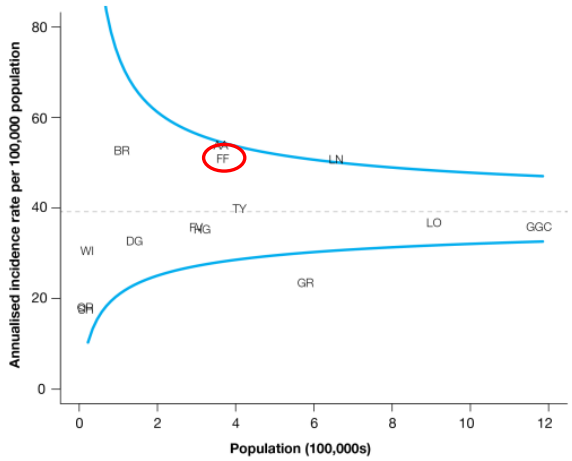
Follow up of all hospital and community cases continues to establish risk factors for CDI

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

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q2 (April – June) 2022 **(Q1 2022 HPS National comparison awaited)**				
In Q2 2022 NHS Fife had:	70 ECBs	35 HAI/HCAIs 35 CAIs	This is UP from	66 Cases in Q1 2022
Q2 2022 There were **11** Urinary catheter associated (1 of which was from a Suprapubic catheter) ECBs, which was significantly higher than during Q1 2022, when there were **7 CAUTIs** (2 of which were in patients who self- catheterise). Please note that 1 of the Q2 2022 CAUTIs was associated with another board.				

Q1 (Jan-Mar) 2022			
HPS Validated data ECBs with HPS commentary *Please note for HPS reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **31.6**	Per 100,000 bed days	CAI ECBs rate: **50.9**	Per 100,000 Pop
No of HCAI ECBs: 27		No of CAI ECBs: 47	
This is **ABOVE** National rate of 30.5		This is **ABOVE** National rate of 39.2	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

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

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

2021-2017 NHS Fife's Urinary catheter Associated ECBs –

HPS data Q1 2022 data still awaited

Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2022 Q2 2022	TBC	**33.3%***	
2022 Q1	17.6%	**0%**	* Locally calculated data- TBC by HPS when Q1 data published on Discovery
2021 TOTAL	16.0%	**15.4%**	
2020 TOTAL	16.4 %	**27.5 %**	
2019 TOTAL	16.1 %	**24.5 %**	
2018 TOTAL	14.5 %	**24.2 %**	
2017 -TOTAL	11.8 %	**10.4 %**	
Data from NSS Discovery ARHAI Indicators			

Healthcare Associated Infections (HCAI)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HCAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2022 Q2	TBC	**35%***	
2022 Q1	21.2%	**33.3 %**	* Locally calculated data- TBC by HPS when Q1 data published on Discovery
2021 TOTAL	27.0%	**36%**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
2018 TOTAL	22.1%	**36.6 %**	
2017 TOTAL	18.3 %	**35.3 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned following a raised ECB CAUTI incidence. The IPC Surveillance team continue to liaise with the Urinary Catheter Improvement Group last held in July and the next meeting planned for October 2022. This group aims to minimize urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheter insertion/maintenance/removal and self-removal, furthermore, to establish catheter improvement work in Fife.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR to provide further learning from all ECB CAUTIs.

Monthly ECB reports and graphs are distributed within HSCP and Acute services
There has been 3 trauma associated ECB to date in 2022.

CAUTI bundles have now been installed onto Patientrack in February 2022 and are awaiting to be trailed on a ward within VHK before being rolled out across the board. This bundle should ensure that the correct processes are adhered to for the implementation and maintenance of all urinary catheters within NHS Fife inpatient wards. Acute services engagement and a HON lead will be required to assist the roll out of this CAUTI bundle.

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

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

5.1 Trends

- Unable to report

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 4 (Jan-Mar 2022) was **96.2%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the National Monitoring Framework for NHS Scotland National Cleaning Services Specification. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

Domestic Location	Q1 Apr-Jun 22	Q4 Jan-Mar 22
Fife	96.0↓	96.2%
Scotland	95.4	95.5%

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (Apr-Jun) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q1 Apr-Jun 22	Q4 Jan-Mar 22
Fife	96.3↓	96.8
Scotland	96.7	96.7

- The Estates Monitoring – quarterly compliance report result for Quarter 1 (Apr-Jun) 23 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

· Areas with results below 90% for all Hospital & Healthcare facilities have been identified to relevant managers for action.

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7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place.

Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any) & how many days the closure lasted.

A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda.

All ward/ bay closures due to Norovirus & Influenza are reported to HPS weekly plus all closures due to an Acute Respiratory Illness (ARI).

All Influenza patients admitted to ICU are also notifiable to HPS

July – end of August 2022

Norovirus

There have been no new ward closures due to Norovirus or suspected outbreak since last ICC report

Seasonal Influenza

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

Weekly national seasonal respiratory report- Week 34, **week ending 28th of August 2022**

In week 34, There were:

- There were 42 influenza cases: 35 type A (subtype unknown), one A(H1N1)pdm09, five A(H3) and one type B.
- Influenza incidence remained at **Baseline** activity level overall. All age groups were at **Baseline** activity level.
- In week 34, RSV, coronavirus (non-SARS-CoV-2), HMPV, parainfluenza, rhinovirus and *Mycoplasma pneumoniae* remained at **Baseline** activity level. Adenovirus decreased from Low to **Baseline** activity level.

7.2 COVID-19 pandemic

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

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

COVID-19 incidents/clusters/outbreaks July – August 2022, there has been 14 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

COVID-19 outbreaks/incidents reported to ARHAI Scotland March/April 2022				
Hospital	Ward	Total Patients	Deaths	Total Staff
HSCP				
Queen Margaret Hospital	Ward 1 Ward 2 Ward 5 Ward 6	2 12 4 7	0 0 0 0	2 4 0 6
Glenrothes Hospital	Ward 3	7	0	4
Stratheden Hospital	Lomond ward Cairnie House	6 3	0 0	2 4
St Andrews Hospital	Ward 1	13	0	4
ASD				
Victoria Hospital	Ward 6	2	0	0
	Ward 32	2	0	0
	Ward 43	2	0	0
	Ward 41 09/7/22	3	0	0
	Ward 41 17/7/22	2	0	0
	Ward 41 19/7/22	2	0	0

8. Surgical Site Infection Surveillance Programme

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

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been changed, and it is believed the current option under consideration nationally is to resume in Q2 2023. 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, so far, in 2022, compared to 2021, which is also reflected in the cumulative total of HCAIs. However, the number of HCAIs need to remain low to achieve the target set for 2022/2023
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce peripheral vascular device infections and dialysis line infections have been effective but remains a challenge, with local surveillance continuing
- IPCT will continue to support the Addictions Service in addressing the reduction of SABs in PWIDs
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- **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). It is believed the current option under consideration nationally is to resume in Q2 2023. Increased resources and months of preparing will be required to successfully recommence surveillance.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are categorized as:

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

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

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

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

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

Report Cards

	NHS Fife								
	SAB			C Diff			ECB		
Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI / UnKnown	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Apr-22	5	2	7	2	2	4	8	15	23
May-22	3	5	8	3	2	5	12	10	22
Jun-22	5	3	8	3	0	3	15	10	25
Jul-22	5	4	9	4	1	5	13	14	27
Aug-22	3	5	8	3	1	4	10	15	25

Cleaning Compliance (%) TOTAL FIFE											
	Oct 21	Nov-21	Dec-21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Overall	95.8	95.7	96.2	96.1	96.4	96.1	96.2	95.9	95.8	96.4	96.3

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

Cleaning Compliance (%) Victoria Hospital												
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun	Jul	Aug
Overall	95.9	95.7	95.4	96.4	95.2	96.2	96.0	95.9	95.7	95.9	95.7	96.5

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

Hand Hygiene Audits VHK: LanQIP Dashboard VHK

Compliance with Hand Hygiene Bundle - GWP5

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

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	1	0
Jun-22	0	0	0
Jul-22	2	0	0
Aug-22	0	1	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul-22	Aug-22
Overall	96.3	96.7	97.0	96.9	97.5	97.8	96.0	97.2	97.1	96.4	97.6	96.5

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Overall	95.5	95.7	97.0	97.4	96.4	96.5	96.6	96.0	95.4	96.6	95.5	95.9

Hand Hygiene Audits VHK: LanQIP Dashboard QMH

Compliance with Hand Hygiene Bundle - GWP5

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

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-22	0	0	0
May-22	0	0	0
Jun-22	0	0	0
Jul-22	0	0	0
Aug-22	0	1	0

Hand Hygiene Audits VHK: LanQIP Dashboard HSCP

Compliance with Hand Hygiene Bundle - GWP5

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

Out of Hospital Infections

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-22	3	2	1	2	6	15
May-22	1	5	0	2	4	10
Jun-22	3	3	2	0	10	10
Jul-22	2	4	3	1	10	14
Aug-22	1	5	1	1	8	15

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:	**4 November 2022**
Title:	**Review of Deaths of Children & Young People Interim Report**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Claire Fulton, Adverse Events Lead**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The report provides an update on the progress of the Fife Partnership Children and Young Person's Death Review process as it approaches its 1 year anniversary of implementation.

2.2 Background

Scotland has a higher child mortality rate for under 18s than any other western European Country, with over 300 children and young people dying annually. It is estimated that a high proportion of 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 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 a national

data core data set. Within scope are all deaths of babies and children up to their 18th birthday and also to include those up to their 26th birthday if they continue to receive aftercare or continuing care at the time of their death. NHS Fife Review Of Children & Young People Deaths Commissioning Group was established in October 2021. The commissioning groups 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 approach of the completion of the first year implementation of the Commissioning Group, there have been 21 deaths which meet criteria for review. This suggests that the number of deaths being reviewed this year will be slightly lower than the anticipated 30-35 reviews per annum, calculated from the last 5 year average. All 21 deaths have been discussed at the monthly commissioning group. Two reviews, including associated completed data sets, have been approved by the group and are ready for submission to the National Hub when this becomes live. The outstanding 19 reviews and are at varying stages of the process (as shown in the summary diagram below)

Diagram 1. Stages of Child Death Reviews at 31 August 2022

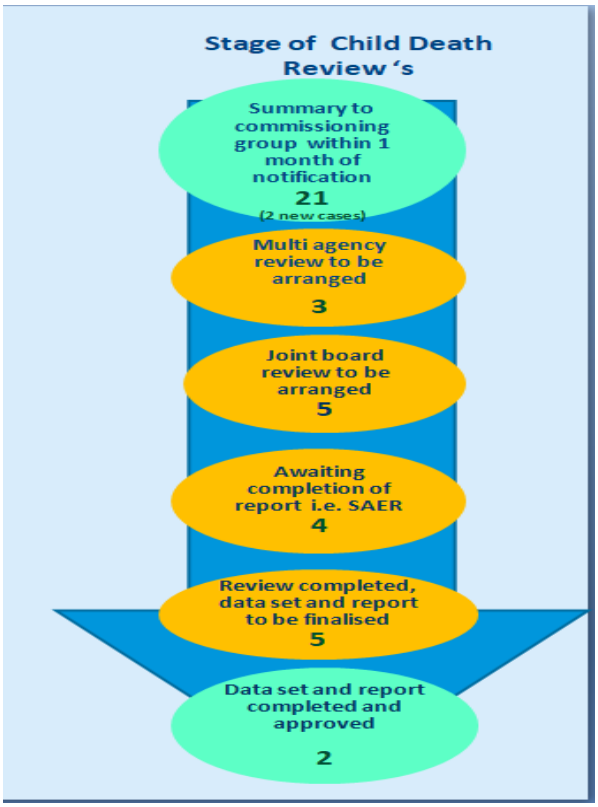
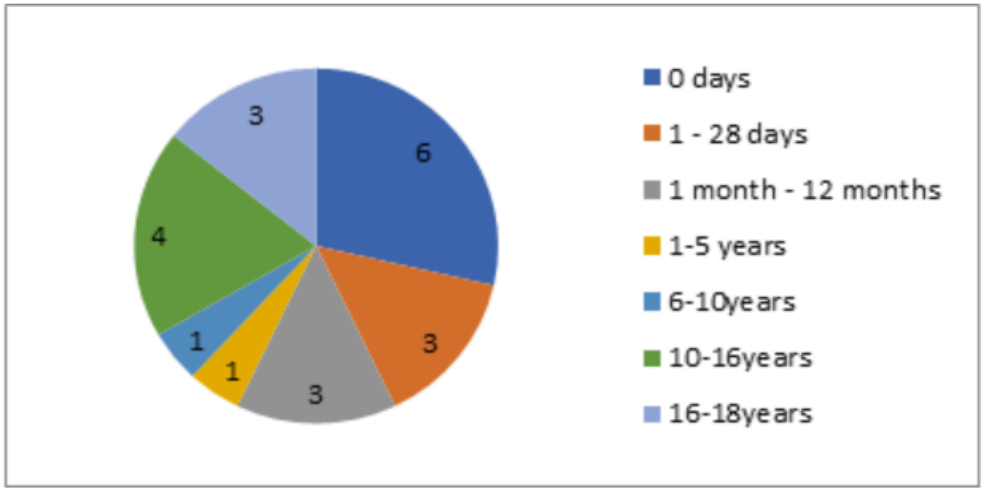


Diagram 2. Summary of cases Age of child at time of death



10 of the 21 deaths were expected deaths, under the categories of prematurity of the newborn with associate complications and genetic or life limiting illness including teenage cancer. 11 deaths were unexpected were these deaths have occurred in hospital a significant adverse event has been commissioned. 4 of the unexpected deaths occurred in the community owing to suicide or road traffic accident. These 4 cases will require a bespoke child death review that will be lead by the Child Death Review Coordinator.

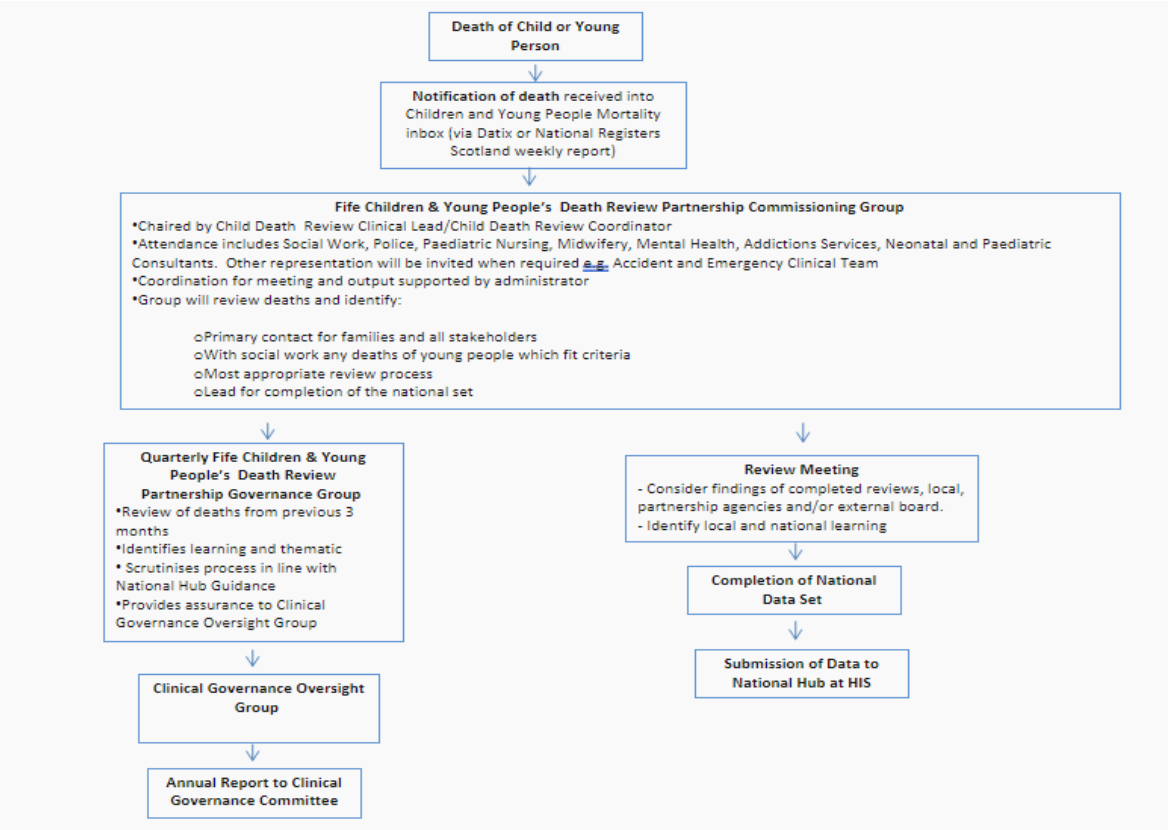
2.3.1 Quality/ Patient Care

- All the key requirements of the national guidelines are being achieved with the exception of:
    - engaging families, in which a plan is in place
    - the submission of completed data sets to the National Hub

Further detail is provided on key recommendations progress in appendix 1.

- Key learning to date relates to the development of the process to review deaths with particular focus on joint board reviews.
- Governance of the review process has been established as per diagram 3

Diagram 3. Governance route



2.3.2 Workforce

The appointment of a Band 7 Child Death Review Coordinator on 1st August 2022 in addition to the Band 4 administrator and dedicated Consultant time completes the substantive staffing of the Child Death Review Team.

It is recognised the highly emotive and sensitive information that is managed by the review team on a daily basis. Weekly huddles have been established that offer peer support and sign posting the staff wellbeing where necessary. The support requirements for the wider workforce involved in child deaths is captured within staff support following an adverse event, with specific targeted work within Womens and Children's Directorate in the form of educational session by the Bereavement Specialist.

2.3.3 Financial

The costs associated with the additional workforce requirement has been agreed and allocated by NHS Fife.

2.3.4 Risk Assessment/Management

The child death review process is at the early stages in 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

Following discussion and advice from the Equality and Human Rights Lead, a stage 1 EQIA is being produced, followed by a stage 2 in the next stages of the review.

2.3.6 Climate Emergency and Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

The Clinical Lead for the Death Review process held an education session to raise awareness of the process on 6 October 2022 which was pen to the multi-agency group and key 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.

- Fife Partnership Children and Young People Death Review Governance Group. 25 August 2022. 0930-1100 via TEAMS. Agreement was reached to provide an interim report to provide an update with an Annual Report in March 2023
- Child Protection Health Steering Group 7 September 2022
- Children In Fife, Fife Council 15 September 2022
- Executive Directors Group 20 October 2022

2.4 Recommendation

- Assurance – for members information

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Key Requirements of the National Guidance, Progress to date

Report Contact
Author Name: Claire Fulton
Author's Job Title: Lead for Adverse Events
Email: Claire.fulton@nhs.scot

Appendix 1

Key Requirements of the National Guidance, progress to date

REQUIREMENT	DESCRIPTION	LOCAL RESPONSE	STATUS/ RATIONALE
Appropriate Infrastructure	To conduct reviews in line with the guidance and to allow for the key data set to be completed	Review of Deaths of Children and Young People Commissioning Group has been established, meeting monthly since October	Delivered
		Process for receiving notifications of deaths has been mapped	Delivered
		Generic email for receiving notifications and information relating to reviews has been set up and working well in collaboration with National Registers of Scotland	Delivered
		Develop a policy and procedures for reviews detailing all existing review processes	31st March 2022
		Completion of national data set	2 cases completed. National Hub not yet accepting any submissions
Single Point of Contact	Named single point(s) of contact for family members and carers after the death of their child or young person. This individual will provide coordination of meetings, communicate on the review process, and assist in the gathering of sensitive data from the families ensure questions from family/ carers are responded to during the review and sign post to bereavement support where required.	Key objective of Band 7 role (Band 7 in post from 15/08/2022)	31/10/2022

REQUIREMENT	DESCRIPTION	LOCAL RESPONSE	STATUS/ RATIONALE
Lead for Reviews	Appointment of a consultant paediatrician lead for reviewing and learning from deaths- stating that job planned time should be allocated for this leadership role	Consultant has provided leadership for the chairing of the commissioning group but has no job planned time for this commitment and associated workload group generates	Delivered
Governance	A Child Mortality review governance group with representation from health and the local authority. To ensure accurate recording, quality of reviews, oversight of reviews being conducted and sharing of learning and progressing improvement plans	Governance Oversight Group has been established. Meeting quarterly.	Delivered
Family Involvement	Contact with families should be considered on a case by case basis and in a sensitive manner so as not to cause further emotional distress. The guidance states that families and carers should be included in the review process in order to ask additional questions and to provide feedback throughout the review process.	Key objective of Band 7 role (Band 7 in post from 15/08/2022)	31/10/2022
Multi-agency and multi-professional input	The membership of the commissioning team should take into consideration the specialties involved in the child or young person's health and social care. This will determine the review panel and ensure that appropriate expertise is present in order to undertake a quality review.	Multi-agency membership of Commissioning Group includes: Consultant Paediatrician responsible for child death reviews (Chair), Associate Medical Director Woman & Children's, Associate Director of Midwifery, Woman & Children's, Associate Director of Quality & Clinical Governance, Clinical Lead Paediatrics Clinical Lead Neonates, Consultant Physician, Paediatrics Clinical Nurse Manager, Clinical Midwifery Manager, Lead for Adverse Events, Clinical Effectiveness Manager, CAMHS Clinical Services Manager, H&SCP, Head of Nursing, Mental Health, H&SCP , Clinical Services Manager, Addictions, H&SCP, Social Work and Police Scotland	Delivered

REQUIREMENT	DESCRIPTION	LOCAL RESPONSE	STATUS/ RATIONALE
National Hub core review data	There is a requirement for Boards to complete and submit a national set. This will be submitted through the HIS Customer Relationship Management (CRM) System. Further confirmation of this system going live along with guidance for data submission is expected.	Complete the full national data set	Delivered
		National Information Sharing Agreement (ISA)has not been issued by HIS so no data has been submitted	Indicative timescale of March 2022
		In the absence of a national ISA an augmented Data Protection Impact Assessment (DPIA) has been developed in collaboration with the Information Governance Team.	Delivered

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Patient Experience and Feedback Report Q2**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This is presented for:

- Assurance
- Discussion

This report relates to :

- Emerging issue
- Government policy/directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported on a monthly basis through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 50% by 31st March 2023)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to

ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
  - Shadowing / observation
  - Walkarounds
  - 15 step challenge

IMPROVING THE EXPERIENCE

It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
  - Framework
  - Leadership
  - Education and training
- Engage staff, patients, families and carers in improvement work

2.3 Assessment

On reviewing the stage 2 complaints, an improving position is evident. There is now a level of detail which clarifies where each complaint is in the process.

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

Stage 2	08/08/2022		15/08/2022		22/08/2022		29/08/2022		05/09/2022		12/09/2022		19/09/2022		26/09/2022	
Total	**192**	**%**	**191**	**%**	**194**	**%**	**188**	**%**	**174**	**%**	**174**	**%**	**171**	**%**	**170**	**%**
Awaiting Statements	71	37.0%	76	39.8%	86	44.3%	73	38.8%	70	40.2%	68	39.1%	73	42.7%	71	41.8%
Returned to Service insufficent statement								0.0%	1	0.6%	1	0.6%	0	0.0%	0	0.0%
Requires PRD Action								0.0%	3	1.7%	12	6.9%	24	14.0%	22	12.9%
Ready to draft	14	7.3%	6	3.1%	1	0.5%	13	6.9%	12	6.9%	6	3.4%	2	1.2%	5	2.9%
Drafting in progress	11	5.7%	15	7.9%	15	7.7%	3	1.6%	2	1.1%	2	1.1%	2	1.2%	4	2.4%
FR out for comment	20	10.4%	21	11.0%	18	9.3%	24	12.8%	21	12.1%	17	9.8%	19	11.1%	18	10.6%
FR out for approval	53	27.6%	56	29.3%	55	28.4%	57	30.3%	48	27.6%	44	25.3%	37	21.6%	39	22.9%
FR with DoH&SC	13	6.8%	10	5.2%	9	4.6%	9	4.8%	13	7.5%	12	6.9%	7	4.1%	5	2.9%
FR with GM for sign off	2	1.0%	2	1.0%	1	0.5%	1	0.5%	1	0.6%	1	0.6%	1	0.6%	0	0.0%
FR with HoS for sign off	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.6%	2	1.1%	2	1.2%	5	2.9%
FR sent to CEO	4	2.1%	2	1.0%	8	4.1%	7	3.7%	2	1.1%	4	2.3%	4	2.3%	1	0.6%

In the last week of September 2022, there were 170 stage 2 complaints in the system, with 9 in total sitting within the Patient Experience Team ready to draft or being drafted (5%).

NB As of 6 October 2022 there are 153 stage 2 complaints, however only 20 of these complaints are within the 20-day target, with 1 ready to draft and 2 with the final draft out for approval. Seventeen (85%) of these complaints are "awaiting statements" with 13 (76%) of the complaints already over the agreed 10-day target in which to have statements returned to the Patient Experience

Team for drafting. Therefore, figures over the next quarter for compliance with responding to a complaint within the national 20-day target are predicted to remain extremely low.

Process mapping, feedback and discussions will take place over the next quarter to investigation 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, focussing on patient experience and feedback.

A quarterly report (Appendix 2) has been developed for the Clinical Governance Committee which captures information on 'Measuring the Experience' and 'Improving the Experience'. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in future reports.

2.3.1 Quality/ Patient Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from complaints and adverse events which can be triangulated with activity and staffing resource.

2.3.2 Workforce

Workforce planning

The Patient Relations Team will be rebranded to the Patient Experience Team and the launch will take place by the end of December 2022. The Patient Relations Team will be referred to as the Patient Experience Team within this document.

The Patient Experience Team establishment is under review, examining workload and workforce planning. Understanding the complexity of complaints and the time required to draft a response, for example, will support workforce planning and the model of complaints management.

The team consists of 1.0 WTE Band 7 team leader; 3.4 WTE Band 6 Patient Experience Officers; 1.8 WTE Band 4 Patient Experience Support Officers; 2.07 WTE Band 3 Patient Experience Administrators.

Additional team support consists of 1.0 WTE Band 6 Bank Patient Experience Officer. A 9-month fixed term 0.69 WTE Band 4 Patient Experience Support Officer post has been advertised. A 1.0 WTE Band 4 Administrator post will be implemented to support administrative and coordination aspects of the complaints handling process. This will release more time for Officers and help streamline systems and processes.

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

2.3.3 Financial

Not applicable.

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 Climate Emergency & Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team

2.4 Recommendation

- Assurance – for Members' information.

3 List of appendices

Appendix 1 – Patient Experience and Feedback Recovery and Improvement Plan, September 2022

Report Contact

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Patient Experience and Feedback

Recovery and Improvement Plan

September 2022

Published Month Year

www.nhsfife.org

CONTENTS

ISSUE: 1	RECOVERY
OBJECTIVE	**Backlog of 'ready to draft' complaints responses is addressed**. 40 responses to be drafted by PR officers as at 01/02/22. This number will inevitably increase as more statements from services are received. Aim is to have no backlog, to allow PR officers to focus on managing new complaints within the Model CHP timescales, and support services to provide statements.

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.1	Provide weekly report on complaints in system to share with operational teams: ECD, PCD, W&CS, CCS, PPCS, C&CS, corporate services	PRT Admin	31/03/22	Weekly report produced providing information on number of complaints within 15 days (green); 15 – 20 days (amber); >20 days (red); status (awaiting statements, for approval etc).	complete
1.2	Prepare complaint information, statements to draft	PRT Admin	31/03/22	Packs prepared for weekend drafting	complete
1.3	Identify staff, experienced in complaints management, to support focused drive on drafting responses	ADoN	31/03/22	Senior nurses working additional hours at weekends to reduce backlog, supporting PRT	complete
1.4	Focus on 'ready to draft' responses by PROs	PR Lead	31/03/22	PROs prioritised drafting backlog of responses	complete
1.5	Highlight 'ready to draft' responses: number, complexity	PRT Admin	31/03/22	Backlog of 'ready to draft' responses cleared	complete

OBJECTIVE	**Define timeline / trajectory for improvement in complaints response times**

No	ACTIONS	LEAD	DATE	PROGRESS	STATUS
1.6	Re-establish weekly meetings with service SPOC	PR Lead	8/4/22	Weekly /bi-weekly meetings re-established	Complete
1.7	Reduce backlog of statements from services and expedite Final Responses awaiting approval	PR Lead / SPOC	31/12/22	Challenges remain with receiving statements within timescales. ECD postponed the complaints process within their services PRD officers workforce remains challenged, mainly due to sickness absence. Accommodating phased returns. As of 36/09/22, 71 (42%) stage 2 complaints are outstanding awaiting statement returns. Reviewing statement memo with aim to reduce duplication, streamlining process and improving quality	In progress

1.8	Analyse data from process mapping exercises and agree improvement trajectory with services	PR Lead / HoPE	31/12/22	Process mapping complete. Initial SharePoint solution for gathering data is not viable. As an alternative solution, new fields have been added to Datix. This has allowed more meaningful data to be entered and exported direct to excel for interpretation. Improvement trajectory not yet discussed with services. New weekly reports are being sent to the services from Datix.	In progress
1.9	Establish focus groups to discuss complaints management with services	PR Lead / HoPE	31/12/22	Initial induction meetings have taken place with HoPE and several HoN and ADoN's. 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	Initial meeting took place to identify potential 'addition' to DATIX system. Additional data fields have been added to Datix as a solution for extracting data. Further ongoing meetings planned to expand on this and to discuss Datix capabilities for extracting more detailed data. Ongoing literature search for coding and categorization of complaints.	In progress
2.2	Data collection and analysis systems to be developed to facilitate 'live' status of complaints, avoid duplication and enable bottlenecks to be identified	ADoN / HoPE	31/12/22	SharePoint not a viable solution for data collection and analysis system. Additional data fields have been added to Datix and data extracted to excel. This negates the need to manually update data onto an excel spreadsheet. Additional fields are being added to Datix for multi-directorate complaints and this will allow us to identify more easily services involved and track the progression of the	In progress

				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	PR Lead	31/12/22	Data systems are currently in place to gather this data. Further work is to be done to enhance the quality of the data. Currently reviewing the feedback Questionnaire in relation to KPI-2 "Complaint Process Experience". A new feedback questionnaire is under design using MS Forms format and a draft copy will be distributed within the organisation and to the public for comments and review before being implemented. MS Forms will also capture 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	PR Lead	31/12/22	Consideration is underway on the drafting of a process to capture this information and once completed will be tested with clinical services.	Not started
2.6	Develop criteria against which quality of draft responses are assessed	PR Lead	31/12/22	Consideration is underway on the drafting of a process to capture this information and once completed will be tested with clinical services.	Not started
2.7	Develop criteria against which complaints are assessed as being upheld, not upheld or partially upheld	PR Lead	31/12/22	Consideration is underway on the drafting of a process to capture this information and once completed will be tested with clinical services.	Not started
2.8	Design template for EDG and CGC SBARs reporting	DoN	8/6/22		Complete
2.9	Design quarterly report template for CGC, including MCHP which will inform Annual Report	DoN	8/6/22		Complete
2.10	Complete Annual Report for SG	DoN	30/9/22		Complete

ISSUE: 3	COMPLAINTS HANDLING SERVICE MODEL				
OBJECTIVE	Review and redesign service model to improve effectiveness and efficiency of processes				
No	ACTIONS	LEAD	DATE	PROGRESS	STATUS

3.1	Carry out detailed process map of PRO work	PR Lead	31/12/22	Process mapping to be arranged	In progress
3.2	Carry out detailed process map of PR administrators' work	PR Lead	22/4/22	Process mapping undertaken	Complete
3.3	Review outcomes and implement recommendations from process mapping sessions	HoPE	31/12/22	Outcomes being reviewed and recommendations considered	In progress
3.4	Benchmark complaints management teams / processes across other Boards and public sector agencies	PR Lead	31/12/22	Ongoing contact to be made with all Boards to review establishments, documentation and processes	In progress
3.5	Process mapping analysis to elicit gaps, duplication, more efficient way of working	PR Lead	31/12/22	Process mapping underway with Quality Improvement project manager	In progress
3.6	Proactively seek feedback from complainants re the complaints handling process (as per KPI) (will also support QI)	PR Lead	31/12/22	Questionnaire sent with all final response letter as of 1/4/2022. A new feedback questionnaire is under design using MS Forms format and a draft copy will be distributed within the organisation and to the public for comments and review before being implemented. MS Forms will also capture response rates and data that can be used for future learning and quality improvement. Feedback "opt in" box has been added to Datix which will allow us to run a report and identify complainants that wish to engage with the feedback process.	In progress
3.7	Poor uptake with feedback from complaints re the complaints handling process (as per KPI)	HoPE	30/11/22	Change format of Questionnaires sent with all final response letters, from PDF to a more user friendly word document. Exploring MS Forms for feedback questionnaires. Organisational Learning Group supporting this change as a Quality Improvement Project.	In progress
3.8	Sending email via Datix System	HoPE / PR Lead	30/09/22	Datix systems has been changed to allow the ability to send emails to recipients with NHS straight from the complaint file. This was not activated previously within the Complaints module. This allows direct emails from Datix rather than having to exit Datix, send from MS Mail, copy sent email and paste within the progress note in Datix complaint file. The ability to send emails from Datix has streamlined the process and is a more efficient way of working.	Completed

ISSUE: 4	'IMPROVING THE EXPERIENCE': QUALITY IMPROVEMENT				
OBJECTIVE	Ensure that lessons learned from all forms of patient feedback are used to inform quality improvement and promote patient safety				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
4.1	Link with Organisational Learning Group	ADoN / HoPE	06/10/22	OLG in early stages of development. ADoN co-Chair. Systems and processes being worked through	Completed
4.2	Identify small Tests of Change in department	ADoN	1/4/22	Blended approach to office working has been established, minimum 50% office-based	Complete
4.3	Identify small Tests of Change in Complaints Handling	PR Lead	31/12/22	Identify ToCs following review of outcomes and recommendations from process mapping	In progress
4.4	Review recorded answer phone message	HoPE / PR Lead		Review answer phone message – length, details Ensure information provide in answer phone message is accurate and update Consider allocated telephone extension for internal queries for NHS staff	Complete
4.5	Review complaint "Holding" Letter process	HoPE / PR Lead	30/09/22	Holding letters are issued every 20 days to complainants advising of delays in providing response letters. This has been changed to an email (where possible) which is a quicker process and releases time. The "Holding" letter/email has also been changed to reflect the feedback from patients who were unhappy with the content.	Complete
4.6	Review of the Complaints "Acknowledgement" process	HoPE / PR Lead	31/12/22	Current review of the delays with complainants receiving "Acknowledgement" letters within 3 working days. The current way the data is extracted from Datix is not always accurate and false breaches are occuring. Currently being reviewed by the Datix team and PR Lead.	In progress

ISSUE: 5	WORKFORCE

OBJECTIVE	Ensure that PRT is supported and developed. Ensure that workload and workforce planning is considered in design of team				
No	**ACTIONS**	**LEAD**	**DATE**	**PROGRESS**	**STATUS**
5.1	Support staff well-being	ADoN / HoPE	30/09/22	First 'Spaces for listening' session took place with Chaplain Service in July. Enquire about additional 'Spaces for listening' sessions. It is planned that these sessions will be provided every 3 months and staff are keen to continue with this. The second session took place 29/09/22.	Completed
5.2	Appoint additional PR officer via bank contract to focus on expediting draft responses	ADoN	1/5/22	Commences in post 31/5/22.	Complete
5.3	Leadership: recruit Head of Patient Experience (HoPE)	ADoN	7/4/22	Post appointed to	Complete
5.4	Ensure PDPs undertaken to support staff development	PR Lead	31/12/22	HoPE to confirm progress with PR Lead Email sent to staff to populate TURAS PDP prior to arranging one to one to discuss	In progress
5.5	Source training opportunities for PRT	PR Lead	31/12/22	HoPE to confirm progress with PR Lead Exploring training in relation to complaints that relate to Information Governance	In progress
5.6	Develop system to categorise complaints from 'simple' to 'complex' to provide approximate time to draft response	HoPE / PR Lead	31/12/22	Ongoing literature search for coding and categorization of complaints	In progress
5.7	Measure workload to support workforce planning	PR Lead	31/12/22	HoPE to confirm progress with PR Lead Ongoing review of caseloads, roles and responsibilities	In progress
5.8	Review of PR team roles and responsibilities	HoPE / PR Lead	30/11/22	Ongoing review of systems and process along with tasks, roles and responsibilities. Test of change commenced 09/08/22 with additional admin support for Senior Complaints Officer Test of change to commence 11/08/22 with PR Support Officer reviewing incoming mail to PR department, releasing PR officers to draft complex complaints	In progress
5.9	Establishment and budget	HoPE / PR Lead	30/11/22	Benchmarking and reviewing current establishment, banding and roles within PR department Review of current budget Review of current vacancies within establishment	In progress

				Fixed term 0.69 WTE Band 4 PR Support Officers post has been advertised and an Administrator 1.0 WTE Band 4 post is currently being reviewed.	
5.10	Rebranding of Team	HoPE / PR Lead	31/12/22	Communications have provided 3 design options for Rebranding of Patient Relations Team to Patient Experience Team. This is currently with a small group within the public for their review and comments.	In progress

Patient Experience and Feedback

PEaF Quarterly Report (Q2) for Clinical Governance Committee

July - September 2022

Published Month Year

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Introduction

Person-centred Care

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- respect for patients' values, expressed needs and preferences
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- 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 Q2 include:

- **199** stories, viewed **17,390** times in all:
  - July 61 stories
  - August 68 stories
  - September 70 stories

In Q2, Care Opinion moderators rated the stories as:

- Not critical 82% (163)
- Minimally critical 7% (14)
- Mildly Critical 7% (14)
- Moderately critical 4% (8)

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	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	Total
Compliment	218	182	287	266	953
Learning from Excellence	21	21	22	4	68
Comments and Feedback	7	6	10	4	27
Total	246	209	319	274	1048

Compliments	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	Total
Acute Services Division - Planned Care & Surgery	86	95	149	127	457
Community Care Services	64	51	35	53	203
No value	22	10	32	28	92
Primary and Preventative Care Services	15	14	18	13	60
Acute Services Division - Women, Children and Clinical Services	14	1	26	29	70
Complex and Critical Care Services	7	7	24	15	53
Community Services (Fife-Wide)	0	0	0	N/A	0
Community Services (West)	1	0	0	N/A	1
Acute Services Division - Emergency Care & Medicine	6	3	3	1	13
Community Services (East)	1	0	0	N/A	1
Corporate Directorates	2	1	0	0	3
Total	218	182	287	266	953

Comments:

CAMERON HOSPITAL – Thank you to all the staff of Letham Ward for all your wonderful care and kindness. You have all; everyone of you helped me to recover from the patient who arrived on the ward in May who couldn't lift his head off the pillow. And now look. Thanks to you I am fit enough after 4 months to go home at last. My wife and I are very appreciative of your professional skills but also your ability to make the atmosphere in the ward such a friendly one. I ultimately won't forget my time with you and wish you all the best for the future.

PLANNED CARE ETC - Thank you to all the Ambulance staff, A&E, Anesthetists, Doctors, Surgeons, Occupational Technicians, Caterers, Cleaners and the Nurses of the Orthopaedics Wards that have had a hand in putting me back together after breaking my femur in a mountain bike crash. A very sincere thank you for all your help and support. You all do a brilliant job and I appreciate all your hard work and long hours. Thank you all so much. A special thank you to Lorraine & Suzi for holding it all together and the genuinely lovely Debbie Anne & Demi.

HOSPICE VICTORIA HOSPITAL - Dear Friends, just a small note and a small gesture to thank you all very much for looking after dad in his final weeks. I very much appreciate your kindness and patience during this difficult time and I'm sure Dad did too (in his own unique way). Hope you enjoy the Heroes as everyone of you are heroes in my eyes. All my love and take care of yourselves.

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.

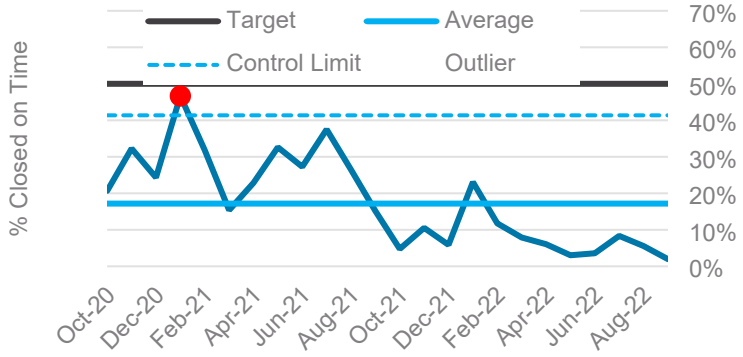
This table presents the total number of Enquiries, Concerns, Stage 1 and Stage 2 complaints received each quarter:

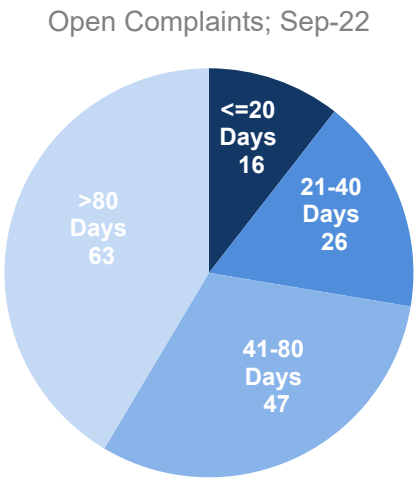
Records logged in Datix Complaints module – 01/07/2022-30/09/2022	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	Total
Stage 1 Complaint	174	113	109	151	547
Stage 2 Complaint	103	122	108	102	435
Concern	82	126	176	150	534
Enquiry	149	104	63	120	436
Total	508	465	455	523	1951

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 Relations Team over this difficult period. A Recovery and Improvement Plan has been developed to improve performance. The Model Complaints Handling Key Performance Indicators are appended to this report.

Stage 2 closed complaints and % closed within timescale

STAGE 2	2021 Oct	2021 Nov	2021 Dec	2022 Jan	2022 Feb	2022 Mar	2022 Apr	2022 May	2022 Jun	2022 Jul	2022 Aug	2022 Sep
Closed Complaints	21	19	17	13	17	38	34	33	29	24	54	51
% closed within timescales	**17**	**11**	**7**	**12.2**	**11.8**	**7.9**	**5.9**	**3**	**3.4**	**8.3**	**5.5**	**2**





Themes (*The quarterly ranking of each theme is highlighted in brackets).*

	Issue noted in Complaint	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2
1	Disagreement with treatment / care plan	47 (1)	64 (1)	50 (2)	11 (1)
2	Co-ordination of clinical treatment	28 (4)	62 (2)	54 (1)	8 (2)
3	Staff attitude	31 (2)	46 (3)	32 (3)	5 (3)
4	Unacceptable time to wait for the appointment / admission	31 (3)	41 (4)	24 (4)	2 (7)
5	Lack of support	16 (6)	26 (5)	22 (5)	1 (9)
6	Telephone		24 (6)	0	3 (6)
7	Poor nursing care		18 (7)	16 (8)	5 (4)
8	Face to face		15 (8)	27 (7)	4 (5)
9	Lack of a clear explanation	23 (5)	15 (9)	22 (6)	2 (8)
10	Insensitive to patient needs	12 (7)			1 (10)
11	Patient has been sent no communication	11 (8)			0 (11)

The top 4 themes each quarter are:

- Disagreement with treatment / care plan
- Coordination of clinical treatment
- Staff attitude
- Poor Nursing Care

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) Q2	Negative Themes (Care Opinion) Q2	Negative Themes (Complaints) Q2
Staff	Communication	Disagreement with treatment / care plan
Care	Care	Co-ordination of clinical treatment
Friendly	Doctor	Staff attitude
Professional	Nurse	Poor nursing care
Nurses		Face to face
Communication		Wrong diagnosis
Kind		Telephone
Doctor		Letter wording
		Lack of explanation
		Lack of a clear explanation

What was good?

What could be improved?

Locations receiving most complaints:

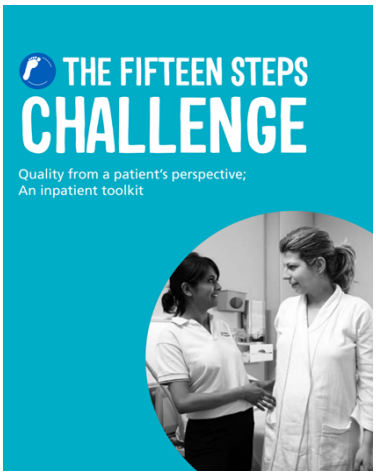
1. Emergency Department *(care and treatment; communication; staff attitude; delays)*
2. Mental Health (*treatment plan disagreement; communication; staff attitude)*
3. Medicine of the Elderly *(care and treatment; staff attitude; delay in discharge)*

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.** A survey has been developed to capture the experience of the person making the complaint in relation to the complaints service provided. The survey will be reported through Datix. We have tested a number of methods to obtain feedback with poor results. Our feedback forms were often returned only when the complainant was dissatisfied with the complaint outcome and so we ceased to use these. These have been re-introduced and again feedback has been poor. Currently review digital options and the plan is to also amend the feedback and complaint form to contain an 'opt in' feedback section. This will allow us to obtain feedback each month by contacting a random selection of complainants who have opted in.

'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 newly appointed 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			
SPSO decisions	4	3	4	3	14	6	4			
SPSO cases fully upheld	1	0	2	1	4	1	1			
SPSO cases partly upheld	0	0	0	1	1	3	2			
SPSO cases not upheld	2	3	2	1	8	2	1			
Cases not taken forward	1	1	0	2	4	6	1			

New SPSO cases this quarter

This quarter, 13 new information requests have been received. These relate to the following services:

- Emergency Care: 9
- Planned Care: 4

New SPSO decisions this quarter

There were 4 new decisions received from the SPSO this quarter.

- 1 Fully upheld
- 2 Partially upheld
- 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 this first quarter with a poor response, only one form returned. To help improve response rates the format of the form has been changed from PDF to Microsoft Word, as this format is more user friendly to complete.*
- *A preliminary draft Feedback Questionnaire has been created on MS Form. The questions will be shared for comments and review before being rolled out and implemented.*
- *An "opt in" option has been added to Datix which will be used to run a monthly report highlighting complainants that have given consent to participate in providing feedback.*
- *A new process for obtaining feedback in relation to the complaints handling process is being created. This will look at when and how to request and obtain feedback as well as data collection.*

Indicator Three: Staff Awareness and Training

Subject Title	No. of staff			Notes
Good conversations (Gc) (3 day course)	NHS	SWFC	VOL	Figures provided for NHS, Social work / Fife Council, Voluntary Sector
	7	6	2	
Gc half- day intro course	3	7	2	
Gc Foundation Management	13			Good Conversations training is also provided as a half-day session on the 5 day Foundation Management programme
Human Factors	-			NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.

Indicator Four: The total number of complaints received

****Please note** – we are unable to provide the data for Primary Care Services for Q2 (July to September 2022) for Indicators 4b and 4h-4k as the Primary Care Services request this information at the end of the quarter (beginning October 2022). As it takes a while to collate this information the data for Q2 will not be available until nearer the time of the next quarter. As such, we cannot complete the total figures for these services for Q2.

	Q3	Q4	Q1	Q2	Total
4a. Number of complaints received by the NHS Fife Board	219	155	217	253	844
4b. Number of complaints received by NHS Primary Care Service Contractors	186	114	211		
4c. Total number of complaints received in the NHS Board area	**405**	**269**	**428**		

NHS Fife Board - sub-groups of complaints received

	Q3	Q4	Q1	Q2	Total
4d. General Practitioner	146	125	81	11	363
4e. Dental	4	1	1	3	9
4f. Ophthalmic	0	0	0	0	0
4g. Pharmacy	67	52	27	0	146
Total - Board managed Primary Care services	**217**	**178**	**109**	**14**	**518**

4h. General Practitioner	133	81	128		
4i. Dental	1	1	3		
4j. Ophthalmic	0	0	0		
4k. Pharmacy	52	27	80		
Total – Independent Contractors	**186**	**109**	**211**		
4l. Combined total of Primary Care Service complaints	**403**	**287**	**320**		

Indicator Five: Complaints closed at each stage

	Number				As a % of all NHS Fife complaints closed (not contractors)			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Number of complaints closed by the NHS Board *(do not include contractor data, withdrawn cases or cases where consent not received).*	**219**	**155**	**132**	**264**				
5a. Stage One	162	87	107	136	74%	56%	81%	51%
5b. Stage two – non escalated	44	59	24	110	20%	38%	18%	42%
5c. Stage two - escalated	13	9	1	18	6%	6%	1%	7%
5d. Total complaints closed by NHS Board	**219**	**155**	**132**	**264**	**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			
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
6a. Number of complaints upheld at stage one	62	16	24	35	39%	19%	25%	29%
6b. Number of complaints not upheld at stage one	65	53	51	63	41%	63%	52%	52%
6c. Number of complaints partially upheld at stage one	31	15	23	23	20%	18%	23%	19%
6d. Total stage one complaints outcomes	**158**	**84**	**98**	**121**	**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			
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
6e. Number of non-escalated complaints **upheld** at stage two	6	1	8	13	20%	6%	42%	25.5 %
6f. Number of non-escalated complaints **not upheld** at stage two	13	9	9	25	43%	53%	47%	49%
6g. Number of non-escalated complaints **partially upheld** at stage two	11	7	2	13	37%	41%	11%	25.5 %
6h. Total stage two, non-escalated complaints outcomes	**30**	**17**	**19**	**51**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints Escalated complaints	Number				As a % of all escalated complaints closed by NHS Fife at stage two			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
6i. Number of escalated complaints **upheld** at stage two	0	1	0	2	0%	14%	0%	14%
6j. Number of escalated complaints **not upheld** at stage two	8	3	1	9	62%	43%	100%	65%
6k. Number of escalated complaints **partially upheld** at stage two	5	3	0	3	38%	43%	0%	21%
6l. Total stage two escalated complaints outcomes	**13**	**7**	**1**	**14**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times

	Q3	Q4	Q1	Q2
7a. the average time in working days to respond to complaints at stage one	8.0	7.2	5.9	14.2
7b. the average time in working days to respond to complaints at stage two	51.1	69.4	44.0	93.8
7c. the average time in working days to respond to complaints after escalation	49.3	84.1	33.0	102.4

Indicator Eight: Complaints closed in full within the timescales

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
8a. Number of complaints closed at stage one within 5 working days.	96	52	75	83	96%	87%	94%	93%
8b. Number of non-escalated complaints closed at stage two within 20 working days	4	8	5	5	4%	13%	6%	6%
8c. Number of escalated complaints closed at stage two within 20 working days	0	0	0	1	0%	0%	0%	1%
8d. Total number of complaints closed within timescales	**100**	**60**	**80**	**89**	**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			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
9a. Number of complaints closed at stage one where extension was authorised	28	10	12	19	47%	27%	38%	35%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	31	27	20	36	53%	73%	62%	65%
9c. Total number of extensions authorised	**59**	**37**	**32**	**55**	**100%**	**100%**	**100%**	**100%**

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Quality Framework for Community Engagement & Participation**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Janette Keenan, Director of Nursing**

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Legal requirement
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report has been prepared to provide assurance to the Committee on public engagement and consultation work undertaken in the last year, and to update the Committee on the implementation of the Quality Framework for Community Engagement and Participation.

2.2 Background

"*Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue*

between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change" (The National Standards for Community Engagement, Scottish Community Development Centre).

"**Planning with People**, Community Engagement and Participation Guidance for NHS Boards, Integration Joint Boards and Local Authorities that are planning and commissioning care services in Scotland" was published in March 2021, replacing CEL4 2010. This guidance supports organisations to deliver their existing statutory duties for engagement and public involvement. "Planning with People" sets out how members of the public can expect to be engaged by NHS Boards, Integration Joint Boards and Local Authorities. It encourages close working between bodies to minimise duplication and share learning.

Healthcare Improvement Scotland and the Care Inspectorate are working with stakeholders to test a **Quality Framework for Community Engagement and Participation** and self-evaluation tool. This will support NHS Boards, Local Authorities and Integration Joint Boards to carry out effective community engagement and demonstrate how these organisations are meeting their statutory responsibilities to engage. In addition, the Quality Framework will provide opportunities to develop practice and share learning.

In 2020, a model for participation and engagement was designed and tested with National Standards for Community Engagement, in the anticipation for the replacement of CEL 4 2010 and introduction of the new guidance.

2.3 Assessment

The model for participation and engagement included the establishment of a Participation & Engagement Advisory Group (PEAG).

PEAG is made up of professional staff who act as a single point of contact for services seeking public participation across Acute Services, HSCP Services, Corporate Services and Localities.

Over the last year there has been 33 requests to the PEAG for support (see Appendix 1) Most notable are the large pieces of work such as the development of the Lochgelly and Kincardine Health and Wellbeing centres, the Mental Health Strategy and the Population Health & Wellbeing Strategy

There has been extensive engagement with staff and the public in relation to the development of the Population Health and Wellbeing Strategy. Information on this work is detailed in a separate paper, "Progress Report on Community and Staff Engagement".

The Draft Quality Framework for Community Engagement and Participation and associated documents were published on 20 September 2021 and were shared with Board Chief Executives and Chairs as well as Chief Officers at Health and Social Care Partnerships and Chairs of Integration Joint Boards. NHS Fife staff have been closely involved in its development.

The HIS–Community Engagement team was developing the Framework alongside the development of the national guidance, "Planning with People". Given that further development of this national guidance was paused until Summer 2022, and with the pressures in the system, it is likely that the Framework itself, will not be finalised before Winter 2022. The latest update on the HIS website was dated August 2022 and states that "draft materials are being tested and will be launched later in 2022".

Preparations are underway to consider the draft self-evaluation tool in anticipation of the introduction of the Quality Framework. Initial review has taken place and a group will be established to drive this work forward.

The self-evaluation will be completed on a 12-month rolling cycle by NHS Boards and Integration Joint Boards. NHS Fife is liaising with Healthcare Improvement Scotland – Community Engagement to discuss this cycle and confirm timescales. This self-evaluation will form the basis of the organisation demonstrating its activity in line with statutory duties as set out in national guidance.

2.3.1 Quality / Patient Care

As highlighted in the Feeley Report, "*Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room*". Meaningful and sustained engagement practice will ensure that a person-centred approach is undertaken in the planning and delivery of services.

The Quality Framework is based on the Quality of Care Approach and was jointly developed by Healthcare Improvement Scotland and The Care Inspectorate, in partnership with other key stakeholders. As well as supporting internal and external assurance, it provides an improvement tool, developed in collaboration with, and primarily for the use of health and social care providers. It has been designed to support reflection and self-evaluation which is an important first stage in any quality improvement journey.

2.3.2 Workforce

Public participation and engagement supports our workforce to consider how to continually improve the ways in which people and communities can become involved in developing services that meet their needs.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland.

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

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled
- Providers of care clearly inform people of their rights and entitlements
- People are supported to be fully involved in decisions that affect them
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this
- People do not experience discrimination in any form
- People are clear about how they can seek redress if they believe their rights are being infringed or denied

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement and consultation

The Framework will identify, support and assure engagement activity within Fife NHS Board in relation to 3 domains:

- routine ongoing engagement
- specific engagement activities relating to service planning and design
- internal governance systems for community engagement activity

Effective communication is critical to the success of self-evaluation. How people hear about it will influence how they approach and engage with the process. Those involved need to understand the following:

- the purpose of the self-evaluation
- how it will be undertaken
- how people will be involved
- the timescales involved
- the steps and activities
- how the information will be used.

HIS CE recommends that the self-evaluation and improvement plans are shared and published on NHS Fife website to demonstrate how the organisation is planning to improve its approach to community engagement. A group will be established to take this work forward.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development.

EDG: 20 October 2022

2.4 Recommendation

- Assurance
- Discussion

3 List of appendices

The following appendices are included with this report:

- Participation and Engagement Activity, 1 April 2021 – 31 March 2022

Report Contact
Janette Keenan
Director of Nursing
Email janette.owens@nhs.scot

PEAG: PARTICIPATION AND ENGAGEMENT ACTIVITY 1 APRIL 2021 – 31 MARCH 2022

	Project Title	Request	Distribution	Outcome / Notes
1.	Misc leaflets	Dianne Williamson	Readability & Format	Comments shared with service
2.	Cancer Governance and Strategy Group	Murdina MacDonald	Request for group representation	Notes of interest collated and shared with service
3.	Mental Health Inpatient Redesign	Hazel Williamson	Request for group representation	Notes of interest collated and shared with service
4.	Kincardine & Wellbeing Centre	Kiran Retour	Request for group representation	Updates will be provided via Sway and links to Participation and Engagement Directory
5.	Dental Services Leaflet	Niall McGoldrick	Readability & Format	Comments shared with service
6.	Your Journey in Fife	Catriona Walker	Readability & Format	Comments shared with service.
7.	Community MH Dev Group	Deborah Dixon	Request for group representation	Meeting to be arranged to discuss participation and engagement across Mental Health Services
8.	Population H&W Strategy	Susan Fraser	Request for group representation	On hold whilst EQIA undertaken
9.	Covid Pack	Yvonne Robertson	Readability & Format	Comments shared with service
10.	Fife Specialist Palliative Care	Kim McPherson	Request for group representation	On hold until new lead comes into post
11.	Fife CAMHS	Emma George	Request for group representation	Feedback Form on CAMHS webpage and shared with 3rd sector agencies
12.	NHS PC Pharmacy Practices	Joyce Kelly	Request for group representation	Notes of interest collated shared with Service
13.	UCR - Mental Health Workstream	Lynn Cummings	Request for group representation	Lived experience volunteer recruited via Fife Voluntary Action
14.	Using Laxitives Leaflet	Kate Leishman	Readability & Format	Comments shared with service

	Project Title	Request	Distribution	Outcome / Notes
15.	MHAS Fife Eating Disorder Pathway	Lee Cowie	Request for group representation	Individuals and groups identified to engage with as part of re-design.
16.	Major Physical Trauma	Dr Bethany Brown	Request for group representation	Comments shared with service
17.	Child Development Centres Development Plan	Lisa Smith	Comments	Comments shared with service
18.	Cancer Framework	Murdina MacDonald	Consultation	Link shared with distribution networks to take part in Discussion Session
19.	Patient and Carer Information Pack	Murdina MacDonald	Readability & Format	Comments shared with service
20.	Robotic Surgery Leaflet	Karen Wright	Readability & Format	Comments shared with service
21.	High Risk Medication	Kiran Retour	Request for group representation	Currently with Service until group recruit to post and agree structure
22.	NHS Fife Organ & Tissue Donation Committee	Lorna McCallum	Request for group representation	Volunteers now in place
23.	Low Risk Chest Pain	Lorna Jackson	Readability & Format	Comments shared with service.
24.	Long Term Conditions Patient Flyer	Amy Walker	Readability & Format	Comments shared with service
25.	Recovery after Coronovirus Leafelt	Stephanie Crolla	Readability & Format	Comments shared with service
26.	Constipation Leaflet	Tracey Thomson	Readability & Format	Comments shared with service.
27.	Older adult CMHT pathway development	Tracey Henderson	Request for group representation	Meeting to be arranged to discuss participation and engagement across Mental Health Services
28.	Respiratory Psychology Service Leaflet	Fabia Cientanni	Readability & Format	Comments shared with service
29.	Clinical Health Psychology Leaflet	Readability & Format	N/A	Comments shared with service

	Project Title	Request	Distribution	Outcome / Notes
30.	RGR - Cancer Services SG	RGR		Comments shared with service
31.	Better Living with Illness Online Group	Readability & Format	N/A	Comments shared with Service
32.	RGR - Urgent Care Services Fife	RGR		Volunteers now in place
33.	Cancer Services Single Point of Contact Hub Project Group	RGR	N/A	Volunteers now in place

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Integrated Screening Annual Report 2022**
Responsible Executive:	**Dr Joy Tomlinson, Director of Public Health**
Report Authors:	**Cathy Cooke, Public Health Scientist**
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1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to highlight the main points from the integrated screening annual report of the six national screening programmes in NHS Fife.

2.2 Background

Delivery of effective population screening remains a key NHS Scotland priority. Screening policy is set by the Scottish Government Health Directorates on advice of the UK National Screening Committee. The national screening programmes are evidence-based interventions which provide cost effective opportunities to improve the health of individuals.

Each programme has a designated NHS Fife Screening Coordinator. A Public Health Scientist and Project Support Officer work across all the programmes.
Each screening programme has a local performance and governance committee, and specialist clinical input is provided either locally or nationally. Some of these committees

cover more than one Board area where the programme is delivered in collaboration with a neighbouring Board.

For the coordination and quality assurance of the screening programmes, the public health screening team is accountable to the Public Health Assurance Committee, chaired by the Director of Public Health.

2.3 Assessment

This report summarises the key learning, achievements and challenges for each of the screening programmes, and highlights planned policy changes and developments. The report provides a high-level overview of the outcomes being achieved through the screening programmes in Fife. It highlights differences in uptake by deprivation by using the Scottish Index of Multiple Deprivation where possible.

The previous Integrated Screening Report was published in March 2021. Variation in timings of data release and reporting intervals mean that the period covered in this report varies by programme. The publication date for this annual report has been changed to autumn for this and future years to align better with the national data releases. Detailed information on performance indicators can be found in programme specific reports. The impact of Covid-19 and the rate of recovery has varied across the adult screening programmes due to the differences between how the screening programmes are delivered.

Minor amendments were made to the report following scrutiny at the NHS Fife Public Health Assurance Committee on 5 October 2022.

2.3.1 Quality / Patient Care

This report is part of the governance arrangements for screening programmes in NHS Fife which aim to ensure that the screening programmes are operating to the highest standards and that there is equity of provision across Fife.

2.3.2 Workforce

None.

2.3.3 Financial

This paper has no financial impact or capital requirements.

2.3.4 Risk Assessment / Management

Risks are considered for each programme at their respective local governance committee, with the Public Health Assurance Committee maintaining an overview of risks and incidents across all programmes.

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

In general, screening uptake decreases with increasing deprivation across all screening programmes. The screening programmes for which we have data by SIMD quintile in Fife demonstrate a deprivation gradient. Some people will make an informed choice not

to attend screening and it is important those decisions are respected. However, there is clearly still progress to be made to address inequalities in screening participation.

To this end, a number of projects are being taken forward by the public health screening team. These projects include: a screening inequalities needs assessment; supporting those with severe and enduring mental health conditions to engage with screening; making contact with individuals who do not attend diabetic eye screening to discuss perceived barriers to attendance; working with the equality and human rights department to look at supporting people living with disability to participate in screening; and working with general practices to encourage women who have missed cervical screening, particularly during the pandemic, to attend.

2.3.6 Climate Emergency & Sustainability Impact

There are no immediate sustainability issues related to the national screening programmes. Within each of the programmes there are potential opportunities to reduce waste and minimise travel. Given these are national programmes any changes will require national coordination.

2.3.7 Communication, involvement, engagement and consultation

The report is based on evidence from programme specific reports. These provide more detailed information on performance indicators and are scrutinised by their relevant local governance committee.

2.3.8 Route to the Meeting

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

- Public Health Assurance Committee, 5 October 2022.
- Executive Directors Group, 20 October 2022

2.4 Recommendation

Clinical Governance Committee members are asked to take **assurance** from the integrated screening annual report. The report highlights performance metrics, incidents and ongoing activity to improve delivery of screening across the programmes in Fife.

Planned areas of work for 2022/23 are set out at the end of the report, these include continued work to support the recovery of the adult screening programmes, understanding the reasons for non-attendance and specific areas of work to address inequalities in uptake.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Integrated Screening Annual Report 2022

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INTEGRATED SCREENING ANNUAL REPORT 2022

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Version 4	25 October 2022

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Report to the Clinical Governance Committee on 4th November 2022

1 INTRODUCTION

1.1 The Director of Public Health is responsible for determining the overall vision and objectives for public health within the Health Board and across the population of Fife; this includes responsibility for the coordination and quality assurance of national screening programmes.

1.2 Delivery of effective population screening remains a key NHS Scotland priority. Screening policy is set by the Scottish Government Health Directorates on advice of the UK National Screening Committee. The national screening programmes are evidence-based interventions which provide cost effective opportunities to improve the health of individuals and to avert, or to identify at an early stage, serious clinical outcomes.

1.3 NHS Fife is responsible for coordinating local elements of delivery for the six national screening programmes listed below:

- Breast Cancer
- Cervical Cancer
- Bowel Cancer
- Abdominal Aortic Aneurysm (AAA)
- Diabetic Retinopathy
- Pregnancy and Newborn Screening

1.4 Each programme has a designated NHS Fife Screening Coordinator. A Public Health Scientist and Project Support Officer work across all the programmes. Each screening programme has a local performance and governance committee, and specialist clinical input is provided either locally or nationally. Some of these committees cover more than one Board area where the programme is delivered in collaboration with a neighbouring Board.

1.5 For the coordination and quality assurance of the screening programmes, the public health screening team is accountable to the Public Health Assurance Committee, chaired by the Director of Public Health. A review of governance arrangements of the national screening programmes in Fife was undertaken in 2017. A recommendation of this review was that a single Integrated Screening Report would be submitted annually to the Public Health Assurance Committee for scrutiny. The report will be submitted thereafter to the NHS Fife Public Health and Wellbeing Committee.

1.6 The previous Integrated Screening Report was published in March 2021. Variation in timings of data release and reporting intervals mean that the period covered in this report varies by programme. The publication date for this annual report has been changed to autumn for this and future years to align better with the national data releases. Detailed information on performance indicators can be found in programme specific reports.

2 SCREENING AND COVID-19

2.1 At the end of March 2020, in response to the Covid-19 outbreak, the Scottish Government announced a temporary pause to the 5 adult screening programmes: bowel screening, breast screening, cervical screening, diabetic eye screening (DES) and AAA screening. It was agreed that the screening programmes would recommence as soon as it was safe to do so.

2.2 By mid October 2020, routine screening had resumed across all programmes with some reduction in capacity due mainly to physical distancing and infection control measures. There had to be a reduction in the number of participants seen per clinic or session and some screening locations had to be changed, increasing travel time for some participants.

2.3 Due to the differences between how the screening programmes are delivered, the impact of Covid-19 and the rate of recovery has varied across the screening programmes.

2.4 There is a risk that delay in screening for eligible participants, as a result of Covid-19, could result in delayed diagnosis and poorer clinical outcomes for participants. In addition, the increased pressure on health and social care services as a result of Covid, will also impact on the recovery of the screening programmes for some time to come.

2.5 This risk is on the Public Health risk register and is reviewed regularly by the Public Health Assurance Committee. Any emerging issues will continue to be monitored and investigated

3 NATIONAL SCREENING OVERSIGHT FUNCTION

3.1 A new National Screening Oversight (NSO) function was established in 2020 following a review undertaken on behalf of the Scottish Screening Committee and the NHS Chief Executives. The review found that there was a lack of clarity around who has executive accountability and responsibility for national screening programmes, specifically in relation to decision-making, risk and issue management and quality assurance. The review recommended that a new National Screening Executive should be established, led by a Director of Screening.

3.2 The NSO team will enable the Scottish Screening Committee to concentrate on strategic screening issues. All components of NSO are in place with a Director of Screening, a team which includes a Clinical Advisor and a National Screening Oversight Board.

3.3 The NSO team has developed a Guide to National Population Screening in Scotland (NSO/National Services Scotland, March 2022). This provides a high-level overview of the roles, responsibilities, governance structures, commissioning arrangements and operational delivery across the national screening programmes in Scotland.

4 BREAST SCREENING

4.1 The main purpose of breast screening is to reduce mortality from breast cancer by detecting and treating cancers at an earlier stage than they would otherwise present. A secondary aim is to reduce the need for more radical treatment.

4.2 Eligible women aged 50 to 70 years are invited to attend for screening by mammography at three yearly intervals. There are six breast screening centres across Scotland and two of these provide the service for Fife. Screening is provided for women resident in North East Fife by the East of Scotland Breast Screening Programme (ESBSP), which is hosted by NHS Tayside. Women resident in the rest of Fife are screened by the South East of Scotland Breast Screening Programme (SESBSP), which is hosted by NHS Lothian.

4.3 Routine breast screening was paused due to Covid-19 in March 2020. Participants who had already been referred for follow-up investigation and/or treatment before the pause continued to be seen and treated as appropriate. Screening restarted in Fife in August 2020.

4.4 Self-referral appointments for women 71 years and over were also paused in March 2020. A stepped approach to reinstatement of self referrals is being taken. From 29 August 2022, women aged 71 to 74 (+364 days) and women over 75 with a history of breast cancer have been able to register for self referral appointments. Appointments will commence from 24 October 2022.

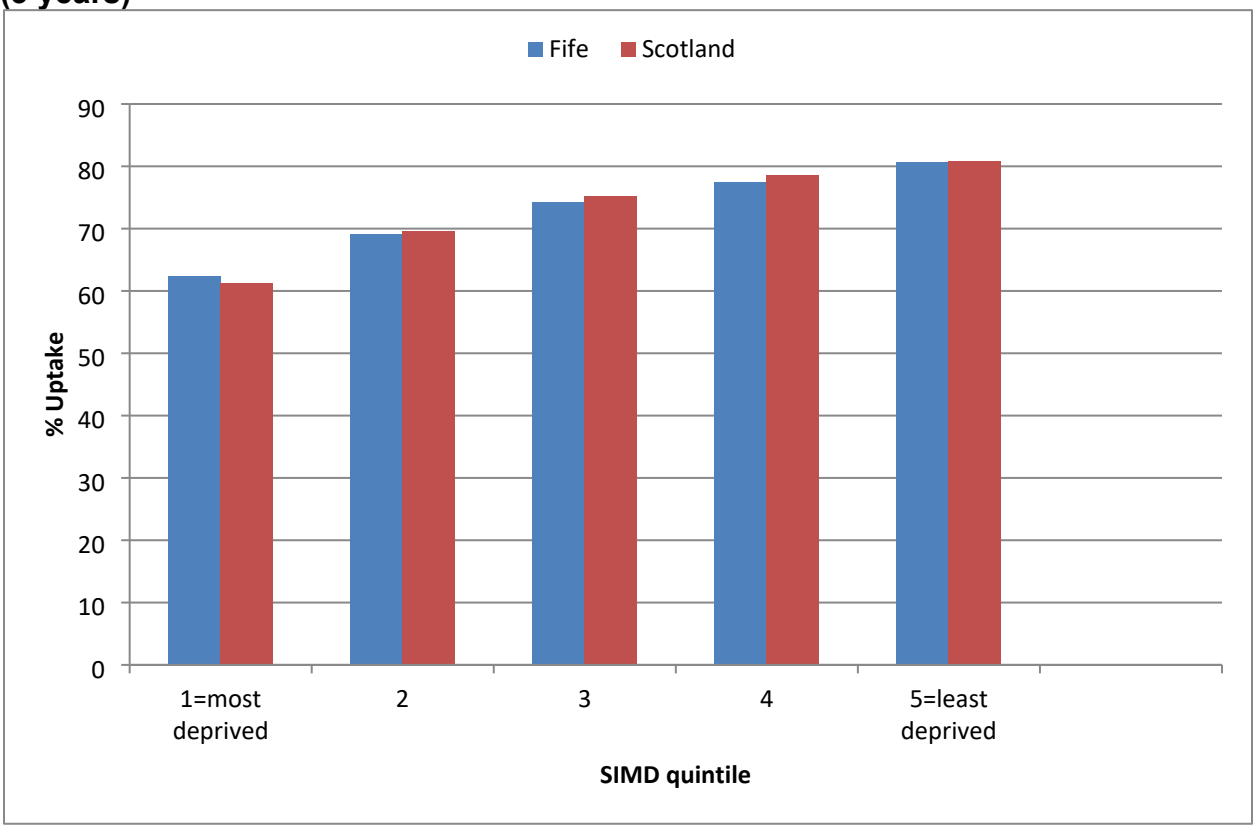
4.5 The phased approach allows self referrals to restart in a way that should not unduly impact on waiting times for women aged 50 to 70 years for whom screening is recommended. The impact on programme capacity and waiting times will be monitored closely.

4.6 As participants are invited every three years it is helpful to examine performance over three-year periods, rather than single years, so that the whole of the invited population can be compared. The data reviewed in this report covers the first year of the COVID-19 pandemic and the pause in the screening programme. During the three-year period 2018/19 to 2020/21, more than 7 in 10 participants took up the invitation for screening (73.1%) in Fife. This meets the acceptable performance

standard of >= 70% and is an increase of 1.2% on the previous reporting period (71.9% in 2017/18 to 2019/20). Uptake is similar in Scotland at 72.3% (and increased by 1.0% on the previous reporting period).

4.7 For those living in the least deprived area quintiles in Fife, uptake was higher (80.6%) than for those living in the most deprived areas (62.3%). This variation is similar in Scotland (figure 1).

Figure 1: Breast Screening uptake by Scottish Index of Multiple Deprivation (SIMD) quintile, Fife and Scotland, participants aged 50-70, 2018/19 to 2020/21 combined (3 years)



4.8 The Healthcare Improvement Scotland (HIS) standards for the breast screening programme were updated in June 2019. The standards have acceptable and achievable thresholds. All 12 acceptable performance standards were achieved in Scotland in the period 2018/19 to 2020/21. Seven of the ten achievable standards were met. The achievable thresholds in uptake for 50-70 year olds, the recalled for assessment rate for 50-52 year olds and the benign biopsy rate for 50-52 year olds were not met. This was also the case for the previous 3-year period, 2017/18 to 2019/20.

4.9 Due to the Covid-19 pause in the Breast Screening Programme and a number of service pressures, there is now a backlog across all breast screening services in Scotland. The acceptable national standard for breast screening invitations is that

≥90% of the eligible population will have been invited within a 36 month round time. NHS Scotland National Services Division (NSD), responsible for national delivery of Breast Screening, has agreed that all boards should aim for a minimum target delivery of a 39-month screening round time by March 2023.

4.10 ESBSP has developed a detailed action plan for recovery in Tayside and NE Fife and has indicated that the 36-month screening round is likely to be achieved by end of August 2023. Actions have included securing an additional mobile unit and workforce for it, training additional radiographers and securing funding for additional assessment sessions. Programme changes have also been introduced to improve service efficiencies and increase screening capacity.

4.11 To address the screening backlog in NE Fife, the following steps have been taken:

- A second screening unit is located in St Andrews; 2 mobile units collocated can accommodate a wider screening geographical pool. The eligible women in this area will be screened over a shorter period, reducing the waiting time for some.
- Temporary boundary changes have been agreed with the South-East Scotland Breast Screening Service who are inviting 1,800 women from the Auchtermuchty and Ladybank practices to the Southeast Breast Screening Unit in Glenrothes.

4.12 Performance continues to be closely monitored by NHS Tayside, NHS Fife Public Health and NSD.

4.13 The SESBSP re-established screening in Fife in August 2020 at reduced capacity to allow for infection prevention and control measures. In 2021 further investment was made to the programme to increase capacity and to address the backlog of women who were overdue for breast screening. This included an additional (6th) mobile screening unit, an increase in radiography staff and weekly Saturday clinics. This has resulted in a steady reduction in the number of women waiting over 3 years (36 months) to be screened.

4.14 Scottish Government has agreed to provide funding to support a 'Modernising Breast Screening Programme' to take forward recommendations from the Breast Screening Review which was published in May 2022. A Programme Board has been established and significant service redesign is anticipated including the development of a new approach to call/recall and the development of static satellite screening centre provision.

4.15 In 2021, anomalies with recall dates for several women in the 'Increased Risk Screening' service in one Board area were detected. This serious adverse event was escalated through NHS Lothian and an AEMT was set up in September 2021. All women who were confirmed as having missed a screen were contacted by the service and followed up appropriately. Plans were also made to ensure completion of follow-up by external boards where some of the patients now reside. There are also plans to restructure the Increased Risk Service to minimise the risk of the

incident reoccurring in the future. One of the Breast Screening Review recommendations was for a national piece of work to be undertaken to assess the potential advantages, feasibility, benefits, and costs of integrating the increased risk service with the national breast screening programme.

5 CERVICAL SCREENING

5.1 The Cervical Screening Programme aims to detect HPV (Human Papillomavirus) and/or changes in cervical cells early to reduce the number of invasive cancers of the cervix. Cervical cytology was replaced with high-risk HPV primary testing in Scotland on 30 March 2020.

5.2 Women aged 25 to 64 years are eligible for routine screening. Cervical screening samples are first tested for HPV and if negative, a recall invitation will be sent in 5 years. If the HPV sample is positive, the sample is tested further for the presence of abnormal cells. Recall for women on a non-routine screening pathway can vary and they can be invited for screening up to the age of 70.

5.3 The incidence of cervical cancer has fallen since the introduction of the national screening programme in 1988. In 2017, an age-standardised rate of 10.1 per 100,000 persons was the lowest incidence recorded in Scotland.

5.4 In the most recent year for which published data are available, there were 18 new cases of cervical cancer in Fife (2020) and 10 deaths from cervical cancer (2020).

5.5 An audit is conducted of all new cases of invasive cancer of the cervix diagnosed in Fife residents during each calendar year. This includes a review of all records connected to an individual's cervical screening history from the past 10 years. NHS Fife also submits data to PHS for the national invasive cervical cancer audit.

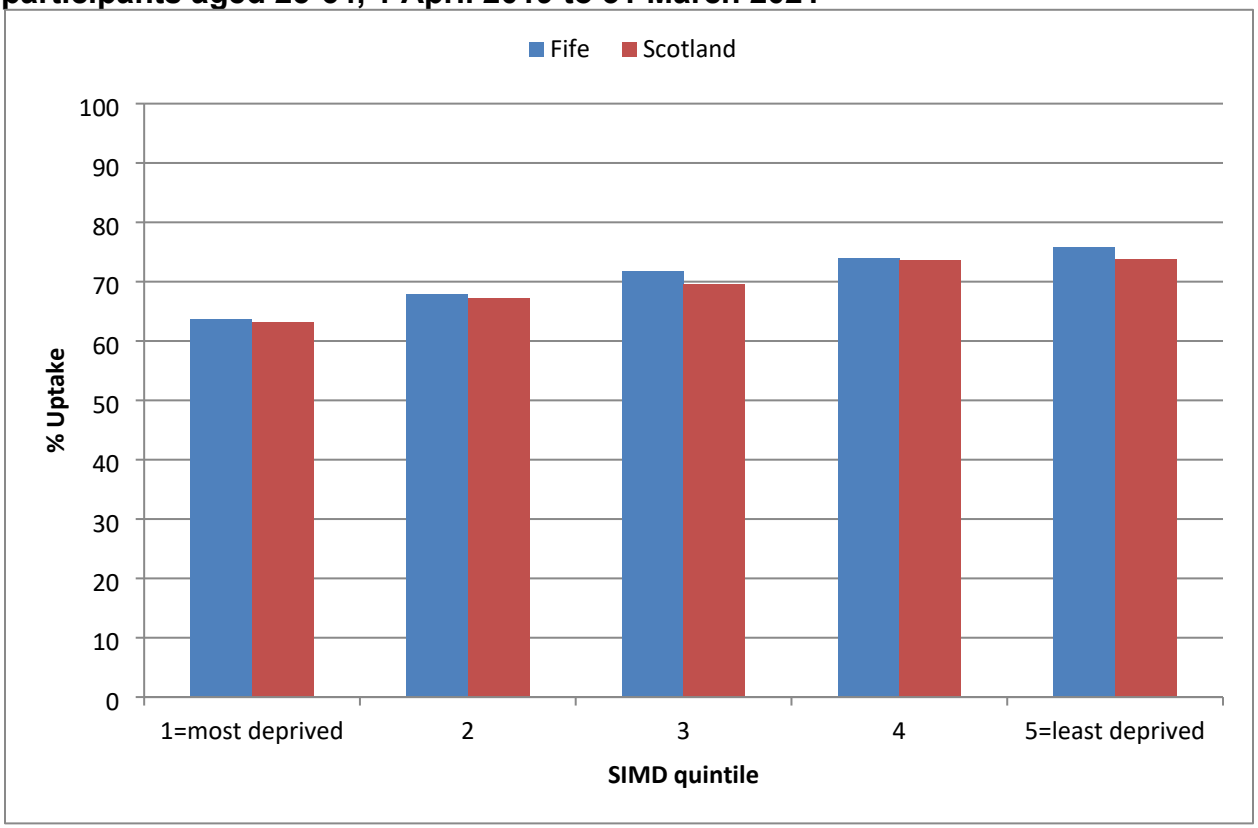
5.6 Cervical screening data presented in this report cover the period 1 April 2020 to 31 March 2021. The Covid-19 pandemic resulted in a temporary pause to cervical screening invitations between March and September 2020 in Fife. The impact of the pause may be reflected in some of the figures reported.

5.7 In 2020/21, 70.3% of eligible women in Fife had been screened within the previous 3.5 or 5.5 years according to age. Uptake in Scotland over the same period was 69.3%. Uptake has been declining for several years.

5.8 When uptake is broken down by 5-year age groups, it is lowest in women aged 25-29 (60.3% in Fife) and highest in women aged 50-54 years (77.5% in Fife). This is also seen in Scotland.

5.9 In women aged 25-64 years, the combined percentage uptake to 31 March 2021 fell with increasing deprivation in Fife and Scotland (figure 2). Uptake was 75.8% in the least deprived quintile in Fife, and 63.6% in the most deprived.

Figure 2: Cervical Screening uptake by SIMD quintile, Fife and Scotland, participants aged 25-64, 1 April 2019 to 31 March 2021



5.10 The majority of cervical cancers are caused by HPV infection. The Scottish HPV immunisation programme started in September 2008 and vaccination is now routinely offered to all secondary school pupils from age 11 to 12 years. At the start of the programme, all 13 to 17 year old girls in Scotland were also offered HPV vaccine through a catch up campaign for a limited time. This catch-up programme finished on 31 August 2011.

5.11 Cervical screening uptake is higher in HPV-vaccinated women aged 24-29 (66.6% in Fife; 68.2% in Scotland) when compared to non-vaccinated women of the same age (41.2% in Fife; 32.2% in Scotland).

5.12 When cervical cytology was replaced with high-risk HPV primary testing in Scotland, there was a reconfiguration of the existing laboratories to deliver both cervical cytology and Hr-HPV testing from two sites only: one in NHS Lanarkshire and one in NHS Greater Glasgow and Clyde. Cervical screening samples from NHS Fife are now processed at Monklands Laboratory, Lanarkshire.

5.13 Laboratory cytology results are not published by individual Board area. During 2020/21 of those testing positive for HPV in Scotland, around a third (65.0%) were negative with no sign of abnormal changes in cells, 30.1% identified low grade cell changes and 5.17% were identified as having high grade cell changes (including cervical cancer).

5.14 The Monklands laboratory has recently introduced some changes to try to maximise capacity and improve turnaround times. The Healthcare Improvement Scotland standard for receipt of results states that a minimum of 80% of individuals should receive their screening results within 14 days of the sample being taken. During the Summer of 2022, it could take up to 6 weeks for a sample to be fully tested and reported due mainly to staffing capacity. The situation is being closely monitored and is improving.

5.15 Using funds from the Scottish Government, Public Health has been working with General Practices to undertake a Covid recovery programme. Practices participating have been funded to actively identify and invite patients who are overdue for cervical screening, with emphasis on those who have missed screening during the Covid pandemic.

5.16 There was an incident in May 2022 when 199 cervical screening samples from Fife were delayed in transit. The 199 samples were taken between 23 and 27 May 2022 and did not arrive at the Monklands Laboratory by courier until 5 July 2022. A Problem Assessment Group was established and actions agreed. Arrangements were made to have the samples transferred to the HPV Reference Laboratory for testing as the Monklands Laboratory can only test samples up to 30 days after collection. The reference laboratory can test samples up to 60 days after collection using the Xpert test. After investigation, the root cause to the delay in transit could not be established. Several steps have been put in place to prevent a similar delay in the future. The courier has also put in place a tracking system. An incident report with further recommendations will go to the Cervical Screening Programme Board.

5.17 In 2021, Scottish Health Boards were required to investigate some records on the Scottish Cervical Call Recall System (SCCRS). These were records of patients indicating that a sub-total hysterectomy had been carried out, and to which the “no cervix exclusion” had been applied. A total of 191 patient records were investigated by the NHS Fife Multidisciplinary Audit Team to assess whether the exclusion had been applied appropriately. The Team completed a lessons learned exercise following on from this investigation as there was awareness that further national investigations would be undertaken. An update report was presented to the Clinical Governance Committee on 1 July 2022.

5.18 An audit of a wider cohort of patients excluded from cervical screening has now to be carried out to provide assurance that the exclusions are appropriate. In Fife this will involve a review of approximately 12,000 patient records. The audit is due to start around November 2022.

5.19 The audit will start with an information gathering exercise to be conducted by administration staff in GP practices. Practices have been reimbursed for this activity which is not funded under the general GP contract arrangements. The Scottish General Practitioners Committee (SGPC) supports this plan.

5.20 The next step will be a review and decision-making process conducted by clinician-led teams at Health Board level.

5.21 Preparations for this work are underway. Discussions are ongoing about the resources required with the national team and Scottish Government.

6 BOWEL SCREENING

6.1 Bowel cancer is the third most common form of cancer diagnosed among men and women in Scotland. People aged 50 years and over accounted for 94.2% of cases diagnosed in Scotland in 2019.

6.2 The aim of the bowel screening programme is to reduce deaths by picking up and treating bowel cancer at an early stage in people with no symptoms. Pre-cancerous polyps (wart-like growths) can also be identified and removed through screening, and this may prevent future cancers developing.

6.3 All men and women registered with a GP and aged between 50 and 74 years are sent a test kit every two years. The test can be completed at home. The quantitative Faecal Immunochemical Test (FIT) has been used in the Scottish Bowel Screening Programme since November 2017. The introduction of FIT simplified the bowel screening process for participants by requiring only one sample to be taken, compared to 3 samples in the past. The FIT also uses an improved, more acceptable, collection device and this led to an increase in participation in the screening programme.

6.4 Data presented in this report, published by PHS in February 2022, cover the period between 1 May 2019 and 30 April 2021. The screening programme was paused for new invitations due to Covid-19 from March to October 2020. This will impact some of the data in this reporting period. To aid recovery of the programme, recall dates were extended by the length of the pause (for one screening round only).

6.5 Between 1 May 2019 and 30 April 2021:

- Of those invited to participate, 65.2% had a complete screening test result in Fife. Uptake is higher in women (66.9%) than in men (63.4%). This is also the case for Scotland where overall uptake is 64.9% (67.0% women, 62.7% men). This represents an increase in participation for both men and women in Fife and Scotland. For the previous, pre-pandemic, reporting period uptake was 63.6% in Fife and 63.2% in Scotland. The Healthcare Improvement Scotland standard for Bowel Screening uptake is 60% of women and 60% of men.

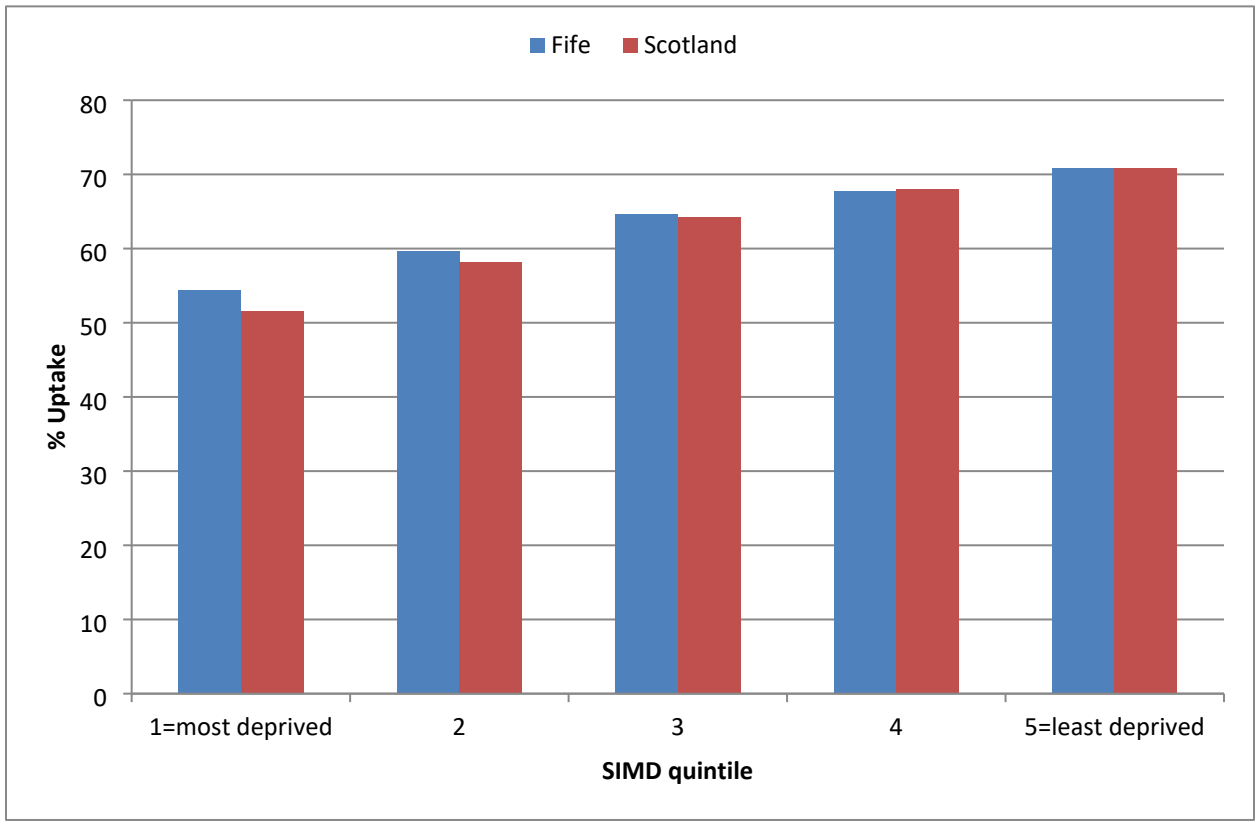
- Uptake for those living in the least deprived area quintiles in Fife was higher than uptake for those living in the most deprived quintiles (figure 3). There was a 16.5 percentage point difference in uptake between the least deprived (70.9%) and most deprived (54.4%). The gap in uptake between the least deprived and most deprived has reduced by 2% since the last reporting period. In Scotland the percentage point difference has also reduced from 20.7 to 19.4.

- The proportion of those completing the screening test with a positive result requiring further investigation in Fife was 2.54%. The rate for men (2.93%) is higher than that for women (2.18%).

- NHS Fife performed better than Scotland in the time from screening test referral to the date a colonoscopy was performed. 75.2% of participants in Fife had a colonoscopy within 4 weeks of referral; this compares with 38.9% in Scotland.

- Of those who had a colonoscopy as a result of a positive FIT, 5.6% had colorectal cancer (Scotland 5.3%) and 45.1% had an adenoma (a benign growth which can become cancerous) (Scotland 46.1%). Detection rates are higher in men than women.

Figure 3: Bowel Screening uptake by SIMD quintile, Fife and Scotland, 1 May 2019 to 30 April 2021



6.6 Bowel screening in Fife has recovered well from the pandemic and there are no current major issues of concern.

7 ABDOMINAL AORTIC ANEURYSM SCREENING

7.1 All men aged 65 years are invited, by letter, to attend a screening appointment for a one-off ultrasound scan to identify the presence of an abdominal aortic aneurysm (AAA). The aim of the screening programme is the early detection and elective repair of asymptomatic AAA to prevent rupture and reduce mortality.

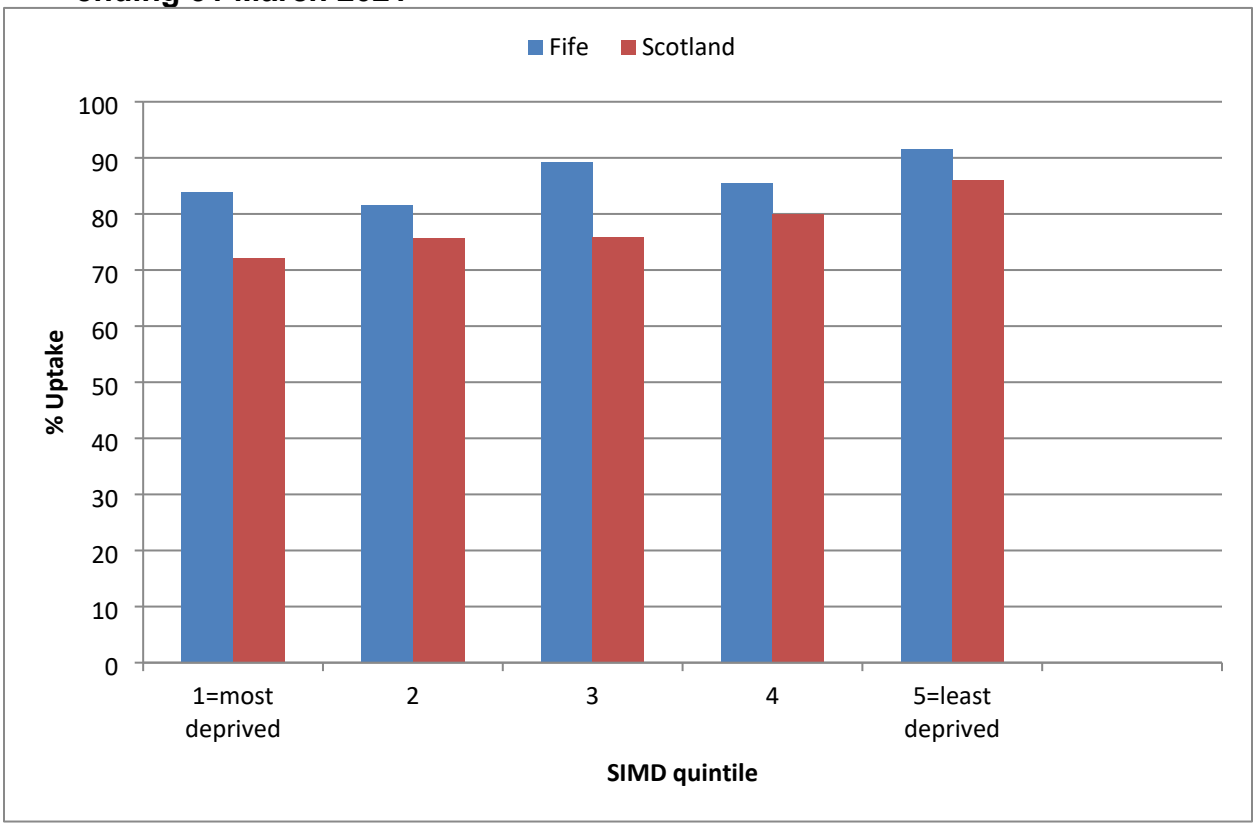
7.2 The Scottish AAA Screening Programme is delivered in Fife in collaboration with NHS Tayside. There are currently four screening clinic sites in Fife. Governance is provided by the joint NHS Tayside and NHS Fife AAA Screening Performance and Governance Committee.

7.3 The reporting period for this programme, 1 April 2020 to 31 March 2021, includes the period from March until September 2020 when the AAA screening programme was paused in Fife due to Covid-19.

7.4 Uptake of AAA screening is measured at age 66 and 3 months. During the year 1 April 2020 to 31 March 2021, uptake was high with 86.2% of eligible men in Fife attending and 78.0% of men in Scotland attending.

7.5 As in the rest of Scotland, uptake for those living in the least deprived area in Fife was higher than uptake for those living in the most deprived area (figure 4). The effect of increasing deprivation on uptake is less marked for Fife than for Scotland.

Figure 4: AAA Screening uptake by SIMD quintile, Fife and Scotland, year ending 31 March 2021



7.6 During the reporting period, operational data indicate that the 'did not attend' (DNA) rate for AAA screening appointments was approximately 5% lower than for preceding years.

7.7 A number of factors may have influenced the drop in DNA rate:

- Between September 2020 and January 2021, all participants were telephoned 48 hours before their appointments to explain the Covid -19 safety measures.
- Scottish Government guidance to stay at home during the pandemic may have meant that some participants were more likely to be available to attend for screening.
- The NHS Tayside & Fife Collaborative rolled out text message reminders for all appointments in April 2021; these are sent out 24-72 hours before appointments.

7.8 Most men have a normal result and are discharged from the screening programme. The number of men with a large aneurysm referred to a vascular specialist for assessment is small for single years so these figures are not presented here. The cumulative total of Fife men who have had an aneurysm detected through routine screening from the implementation of the programme to the end of March 2021 is 244 (1.5%). Of those the majority were small (195, 79.9%), 28 were medium (11.5%) and 21 were large (8.6%). In Scotland the cumulative total of those who have had an aneurysm since the implementation of screening is 1.3%.

7.9 Despite the challenges of the pandemic, NHS Fife met the essential or desirable threshold for all but three key performance indicators (KPIs) during 2020/21.

7.10 The surveillance KPIs measure the attendance at surveillance scans within tightly defined timescales. Men on quarterly surveillance should be tested within four weeks of their appointment due date and men on annual surveillance within six weeks. Given the programme was paused in Fife from late March to September 2020, the target timescales for attendance were missed for nearly all men with surveillance appointments due in these months.

7.11 No Board in Scotland met the KPI focusing on the percentage of annual surveillance appointments due, where men are tested within 6 weeks of their due date. The essential threshold for this KPI is set at ≥90%. The percentage in Fife was 47.1% and in Scotland it was 59.1%. Following the COVID pause, NHS Fife restarted screening slightly later than some Board areas due to the time it took to secure access to clinic locations. During the previous reporting period of 2019/20, 97.3% in Fife were tested within 6 weeks of their due date.

7.12 The KPI focusing on the percentage of quarterly surveillance appointments due, where men are tested within 4 weeks of their due date was also challenging. The essential threshold for this KPI is set at ≥90%. During the previous reporting period of 2019/20, 98.1% in Fife were tested within 4 weeks of their due date. During the year 2020/21, 65.0% of men in Fife and 64.7% in Scotland were tested within 4 weeks. No mainland Board area met the essential threshold for this KPI.

7.13 The KPI on the percentage of men deemed appropriate for surgery and operated on within 8 weeks of screening has been challenging in a number of Board areas since the implementation of the screening programme. This KPI includes men deemed appropriate for surgery who go on to decline surgery; and also men who have co-morbidities that need to be addressed before AAA surgery is recommended. There continues to be close monitoring of men awaiting surgery and the reasons for this and, where possible, delays are minimised. The essential threshold of ≥60% was not met in 2018/19 (28.6%) or 2019/20 (46.2%) in Fife. During the year 2020/21, no men were operated on within 8 weeks of screening in Fife (the number of is men is <5). Only one mainland Board area in Scotland met the essential threshold for this KPI.

7.14 The AAA screening programme staffing has recently returned to normal levels following significant Covid and non-Covid related absences throughout 2021 and the first quarter of 2022. With full staffing (3 screeners) and a health care assistant (appointed for 12 months to help with recovery) and the reimplementation of shorter, pre-pandemic appointment times, it is anticipated that the screening age of participants will be reduced to 65 years and 6 months by January 2023.

8 DIABETIC EYE SCREENING (DES)

8.1 Diabetic retinopathy is a common complication of diabetes which affects the eyes. Untreated diabetic retinopathy is one of the most common causes of visual impairment and blindness. Diabetic eye screening can detect retinopathy at an early stage before any symptoms are apparent.

8.2 In 2016 the UK National Screening Committee recommended revised screening intervals for patients within the DES programme. The recommendation was that the interval between screening tests should change from one year to two years for people at low risk of sight loss. The revised screening intervals began to be implemented in early 2021.

8.3 The 2021 screening annual report shared DES data from the year 1 April 2019 to 31 March 2020. In May 2020, the national software platform for the screening programme (Vector) was replaced with a new system, OptoMize. Verified KPI data reports have not been published since the introduction of OptoMize. This has been due to a number of factors including the Covid-19 pause of screening, prioritising higher risk participants on the restart of screening, the implementation of revised screening intervals, and incorporating optical coherence tomography (OCT) within the screening programme. All these factors impact on how the KPI data are produced and interpreted.

8.4 Producing KPI reports for 2020/21 and 2021/22 is now being prioritised by the DES Collaborative. In the meantime, operational performance data are being closely monitored and shared monthly with all Boards. Some of the KPI data from 2019/20 are shared again here.

8.5 During the year 1 April 2019 to 31 March 2020, people living with diabetes (Type 1 and Type 2) aged 12 and over were invited to attend an annual screening appointment. The total eligible population for diabetic eye screening in Fife was 21,185.

8.6 The proportion of the eligible population who attended at least once for screening during 2019/20 was 75.9% in Fife (72.4% in Scotland). The proportion of the eligible population who had been successfully screened at least once was 75.3% in Fife (71.8% in Scotland). The target is 80%. Uptake is lower than previous years and this is thought to be mainly due to the pause of screening in March 2020 due to Covid-19.

8.7 A challenge to the sustainability of the service continues to be the increasing number of people with diabetes (approximately 5% increase per year across Scotland) and the subsequent increase in demand on ophthalmology and acute services to deliver treatment. The optical coherence tomography (OCT) pathway within screening is working well in Fife and has reduced unnecessary referrals to ophthalmology.

8.8 A Business Plan is being developed to scope out projections around demand for screening over the next five years and staff numbers/skill mix required to meet the demand. It will also look at staff progression and build in resilience in terms of grading and slit lamp skills.

8.9 Following the Covid-19 pause, screening resumed at the end of July 2020. Capacity to screen participants was particularly affected in this screening programme. Appointment times were lengthened to enable enhanced cleaning of equipment and clinic spaces and to reduce the number of people in clinical areas.

8.10 Good progress is being made in reducing the Covid-19 related backlog. The DES team has been able to secure the services of a new screener as well as an extension to the contract of an existing screener. The team has also secured additional screening equipment. Assuming there are no further disruptions or significant staffing issues, it is anticipated that the programme will recover from the backlog before the end of 2022.

8.11 Former Test and Protect Contact Tracing Practitioners have been supporting DES in two projects. The first project involved making contact by telephone with individuals who had not attended diabetic eye screening in the past 30 months. The aim was to discuss the screening programme, find out if there were any barriers preventing attendance and, with their consent, arrange an appointment for individuals at a time and location that suited them. The project is ongoing, and outcomes are currently being analysed.

8.12 A similar project in 2017 found that the referral to eye clinic rate from the DNA cohort of patients was more than four times the Scottish average. This highlighted the importance of continuing to engage with those who do not attend screening

appointments, and that chronic non-attendance from screening can be a significant risk factor for potential sight loss.

8.13 The second project involves contacting individuals by telephone to gather feedback on their experience of using the diabetic eye screening service. Information gathered will be analysed in due course.

8.14 In March 2022, a multi-Board incident was identified that had led to delays in inviting newly diagnosed individuals with diabetes for screening. An adverse event management team, led by National Services Division, was established to manage the incident.

8.15 Between April 2021 and 25 March 2022, demographic details of newly diagnosed patients at 7 new/merged GP Practices failed to be processed into the OptoMize system. There were 59 patients from 3 Board areas quickly identified, correctly processed into OptoMize and invited for screening.

8.16 In total, 29 participants from Fife were affected. All accepted an invitation to be screened and either had no retinopathy, mild retinopathy, or no newly identified retinopathy. No harm as a result of the incident was identified.

8.17 The IT issue has been fixed to prevent any recurrence.

9. PREGNANCY SCREENING PROGRAMMES

9.1 Pregnancy screening covers:

- Infectious diseases (hepatitis B, syphilis and HIV).
- Haemoglobinopathies (sickle cell and thalassaemia).
- Down's syndrome, Edwards' syndrome and Patau's syndrome.

9.2 Where possible the most recent data available are presented in this report. There are some limitations to the data and this affects all Health Board areas. Unlike the other screening programmes, there is no national IT system to support the programme and therefore a lack of comprehensive national data to monitor the performance of pregnancy and newborn screening. Some of the national work set up to determine where the gaps are and how these can be addressed was temporarily paused during the pandemic. Public Health and Intelligence colleagues within Public Health Scotland are leading on this work.

9.3 The aim is to better capture data from many different (and currently unlinked) IT systems used in the pregnancy and newborn screening programmes so that performance can be monitored against key performance indicators (NSS, 2018).

9.4 A national contract has now been established with the providers of the BadgerNet IT system. BadgerNet is a clinical IT system for maternity care. It is not designed

explicitly for reporting screening performance indicators although some are available. NHS Fife maternity service has been using BadgerNet since August 2018. The quality and completion of the data on BadgerNet has improved over time. All Boards except NHS Lothian use BadgerNet.

9.5 The risk that NHS Fife cannot monitor pregnancy and newborn screening comprehensively as systems for robust data reporting are not available is on the NHS Fife Public Health Risk Register.

9.6 For the year 1 April 2020 to 31 March 2021, PHS report that there were 2856 bookings with maternity services by NHS Fife residents; 80.4% were booked by 10 weeks gestation (91.4% by 12 weeks gestation). (Source: PHS, SMR02; data are provisional). These data are based on discharge data following delivery so only include births as the pregnancy outcome. Bookings that lead to other outcomes such as miscarriage or termination are not included.

9.7 These data also include all Fife resident bookings; some Fife residents book in other Health Board areas (e.g. Tayside). It is not possible to report on all Fife residents for all aspects of pregnancy screening. Women resident in Fife who book elsewhere are usually included in data reports of the Board area where they plan to give birth.

10. INFECTIOUS DISEASES

10.1 Data from the NHS Fife microbiology laboratory for this programme have been delayed. This is due to a major laboratory inspection, a total revision of the laboratory system and the significant impact these are having on current capacity. The data will be reviewed as soon as they are available.

11. HAEMOGLOBINOPATHIES

11.1 Haemoglobinopathies (sickle cell and thalassaemia disorders) are serious blood disorders that affect haemoglobin.

11.2 The NHS Fife haematology laboratory received 2871 samples from pregnant women to be screened for haemoglobinopathies during the year ending 31 March 2021; and 2896 during the year ending 31 March 2022.

11.3 No pregnancies were found to be at risk of a significant haemoglobinopathy. A number of carriers were identified (10 in 2020/21 and 11 in 2021/22). Partner testing was declined or unavailable in some cases (<5 cases over the two-year period).

12. SCREENING FOR FETAL DOWN'S SYNDROME, EDWARDS' SYNDROME AND PATAU'S SYNDROME

12.1 First trimester screening is supported by NHS Lothian laboratory service and second trimester screening is supported by Bolton antenatal screening laboratory. For

those pregnancies with a higher chance result from first or second trimester screening, non-invasive prenatal testing (NIPT) is offered as a second line screening test. The laboratory service for NIPT is provided by the East of Scotland Regional Genetic Service based at Ninewells Hospital, Dundee. These arrangements for laboratory provision to support the Down's syndrome, Edwards' syndrome and Patau's syndrome screening programme cover all Scotland.

12.2 For the year ending 31 March 2022, there were a total of 2262 tests from NHS Fife. First trimester screening was provided for 1942 singleton and 26 twin pregnancies. The number of second trimester tests was 294 (13.0%).

12.3 The proportion of complete laboratory request forms is a Key Performance Indicator (KPI) of the Pregnancy and Newborn Screening Programme. The KPI is defined by completion of a number of selected fields on the original request. These essential fields, when completed, provide sufficient information for the woman to be uniquely identified. The essential performance criterion is ≥97% completion. For the year ending 31 March 2022, NHS Fife achieved the KPI with 98.8% completion for first trimester tests; the Scotland rate was 98.0%.

12.4 Standards for the screening programme state that all information should be completed, not just selected fields. When all fields are considered, the NHS Fife completion rate was 96.3%; the Scotland rate was 94.0%.

12.5 Reports on completion rates, stating the amount and type of missing information, are sent to Lead Midwives on a regular basis along with cumulative performance charts. The laboratory also requests feedback on the reasons for incomplete forms if the ≥97% essential threshold for the KPI is not being met.

12.6 During 2021/22 there were 53 referrals for NIPT from NHS Fife following a higher chance serum screening result. As with the other laboratories, submission of incomplete request forms can have an impact on resources, both laboratory staff and midwifery teams. Information was missing from <5 referral forms from NHS Fife.

12.7 The target reporting time for NIPT is 7 calendar days from receipt of the sample in the laboratory to the issue of a final report. The average reporting time for samples during 2021/22 (Scotland) was 5.3 calendar days and 98.6% of reports were issued within the 7 calendar day reporting time.

12.8 The CARDRISS (Congenital Conditions and Rare Diseases Registration and Information Service for Scotland) team in Public Health Scotland is working to improve national information on babies with congenital conditions.

12.9 A congenital anomaly is an abnormality of body structure or function that is present at birth. Anomalies can be due to underlying genetic defects or environmental exposures that affect the development of the baby in the womb.

CARDRISS now captures information on all babies affected by:

- major structural anomalies
- chromosomal anomalies
- recognised syndromes
- inherited endocrine, metabolic, and haematological conditions

CARDRISS will include all:

- live-born babies diagnosed within the first year of life
- stillbirths
- fetal losses at more than 20 weeks of pregnancy
- pregnancies terminated at any gestation due to an anomaly

13. UNIVERSAL NEWBORN HEARING SCREENING (UNHS)

13.1 The universal newborn hearing screening programme aims to identify babies born with bilateral permanent moderate, severe and profound deafness. Evidence shows that introducing an early support programme before 6 months of age leads to better outcomes for speech and language development.

13.2 In Fife, a hospital-based Automated Auditory Brainstem Response (AABR) screening protocol is used. Babies missed in hospital or born at home, and those requiring repeat screening or transferring in from other areas, are offered outpatient appointments.

13.3 During the year 1 April 2021 to 31 March 2022, 3054 Fife resident babies were eligible for screening and 2964 (97.1%) completed screening by 4 weeks corrected age. The essential threshold for this KPI is ≥98%. The essential threshold was met for three quarters of the year but during Q2 (July to September 2021), screen completion at outpatient appointments was delayed for an increased number of babies due to Covid-19 isolation or parental concerns about attending the hospital setting.

13.4 Of the 35 babies requiring an immediate onward referral for audiological assessment, 100% received an appointment within the required timescale (within 4 weeks of screen completion or by 44 weeks gestational age). The desirable threshold for this KPI is >99%.

13.5 Of the 35 babies referred, 29 attended within the required timescale (82.9%). The essential threshold for this KPI is ≥90%. This KPI proved challenging to achieve due to Covid-19 self isolation periods for families which impacted on parents and siblings of babies referred. All babies were offered timely appointments however some families had to rearrange their appointments on more than one occasion.

13.6 During the year 2021/22, eight babies were diagnosed with hearing loss (of varying degrees.

13.7 Scotland figures for UNHS for the year 2021/22 were not available for this report.

13.8 Two different IT Systems are used to support UNHS in Scotland. Twelve Boards (including NHS Fife) use a dedicated module for the hearing screening programme on the Scottish Birth Record (SBR), which is an NHS Scotland IT system used for the recording of births and neonatal data. The two other Boards use the same system used in NHS England. NHS Wales use a development of their child health system for UNHS. An options review is being undertaken to provide an overview of currently available UNHS support systems, identify issues that could impact on the quality of service delivered and make recommendations on the optimum system to support UNHS in Scotland going forward.

14. NEWBORN BLOOD SPOT SCREENING

14.1 Newborn blood spot screening identifies babies who may have rare but serious conditions. The programme includes screening for Phenylketonuria (PKU); Congenital Hypothyroidism (CHT); Cystic Fibrosis (CF), Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD); and Sickle Cell Disorder (SCD). On 20 March 2017, testing was extended to include four further metabolic disorders: maple syrup urine disease (MCUD), isovaleric acidaemia (IVA), glutaric aciduria type 1 (GA1) and homocystinuria (HCU).

14.2 Testing is offered to all newborn babies usually around 5 days of age. The test is done by a midwife who obtains a few drops of blood by pricking the heel. The blood is collected on a card which is sent to the Scottish Newborn Screening Laboratory, Glasgow, for analysis.

14.3 During the year 1 April 2021 to 31 March 2022, the laboratory received 3469 blood spot sample cards from NHS Fife; <5 were suspected of having a condition and referred to a specialist clinician.

14.4 The blood spot sample should be taken between 96 and 120 hours of life. The essential performance threshold for this KPI is ≥90%. During the year 2021/22, the proportion of samples taken in Fife within this timeframe was 92.2%. This compared with 89.6% in Scotland.

14.5 There is a KPI for the percentage of samples that required repeating due to avoidable reasons. Repeating tests impacts on midwifery and laboratory time and can be distressing for parents who have to consent to another heel prick test. The essential performance threshold for this KPI is ≤2%.

14.6 During the year 2021/22, there were 6.26% avoidable repeat tests from NHS Fife, and 4.26% from Scotland. The most common reason was that the sample was insufficient.

14.7 In order to try to minimise the number of avoidable repeat tests required for the programme, a Clinical Education Midwife has developed an education package and competency framework for midwives in Fife. The avoidable repeat rate is closely

monitored with monthly feedback to individual midwives and further training can be arranged where appropriate. Recent figures show some improvement.

14.8 There is also monitoring of the proportion of samples where information, essential to accurately interpreting the results, is not recorded on the blood spot card. During 2021/22 in Fife this proportion was 1.15%; in Scotland it was 1.61%.

14.9 Following a recent incident in another Board area, when best practice was not followed and newborn blood spot testing was delayed, all Boards have been advised by National Services Division to review processes in place and adherence to protocols. Boards were asked to review:

- that child health records departments were running essential reports.
- that relevant staff are aware the laboratory should be contacted first to check whether the sample has been received (to avoid unnecessary repeat testing).
- how the relevant teams are made aware of overdue samples, action required and timescales to be met; and
- emails notifying midwives/midwifery teams of overdue blood spot samples are easily identifiable to be prioritised for action, and there is a system for monitoring that the request has been seen and actioned.

14.10 Work is ongoing to strengthen the processes in place within NHS Fife.

15. PLAN FOR 2022/23

15.1 Assuring the delivery of effective population screening is a priority for NHS Fife Department of Public Health.

15.2 In general, uptake decreases with increasing deprivation across all screening programmes. The screening programmes for which we have data by SIMD quintile in Fife demonstrate a deprivation gradient. Some people will make an informed choice not to attend screening and it is important those decisions are respected. However, there is clearly still progress to be made to address inequalities in screening participation.

15.3 As part of the Scottish Government's commitment to reduce inequalities in screening, there is an inequalities fund for initiatives that could help address barriers for those less likely to engage.

15.4 NHS Fife received funding from the inequalities fund to participate in a collaborative project with NHS Borders, NHS Tayside, and the Mental Health Foundation. The Bridging the Gap project aims to support those experiencing severe and enduing mental health conditions to engage with screening programmes. Progress was delayed due to Covid-19 but a nurse has been appointed to take forward the work in Fife.

15.5 It is important that activities to reduce inequalities are evidence based. A screening inequalities needs assessment is ongoing. Key stakeholders involved with various screening programmes have been interviewed. A literature review of initiatives that have succeeded in reducing inequalities in screening is being undertaken. The aim is to produce an evidence-based action plan to address inequalities in screening in Fife.

15.6 Another Fife project, as mentioned earlier, involved contacting individuals who had not attended diabetic eye screening in the past 30 months. The aim was to discuss the screening programme, find out if there were any barriers preventing attendance and, with their consent, arrange an appointment for individuals at a time and location that suited them. The outcome of this project will be analysed in due course.

15.7 The public health screening team is working with the Equality and Human Rights department to ensure that people living with disability in Fife are supported to participate in screening programmes.

15.8 The public health screening team will continue to work with General Practices in Fife to encourage women who have missed their cervical screening, especially during the COVID pandemic, to attend for screening.

15.9 The National No Cervix Incident Wider Cohort Audit is due to commence in November 2022. NHS Fife will be auditing the records of approximately 12,000 women.

15.10 In summary, during 2022/23, the Public Health Screening Team will:

- Continue to work with local and national screening programme groups to further facilitate ongoing recovery of adult screening programmes from the impact of COVID-19.
- Continue work to understand reasons for non-attendance and explore methods to address these.
- Continue work to address inequalities within the screening programmes.

16. DIRECTORY OF SCOTTISH SCREENING PROGRAMME STATISTICS

- Scottish Breast Screening Programme Statistics: https://publichealthscotland.scot/publications/scottish-breast-screening-programme-statistics/scottish-breast-screening-programme-statistics-annual-update-to-31-march-2021/

- Scottish Cervical Screening Programme Statistics: https://publichealthscotland.scot/publications/scottish-cervical-screening-programme-statistics/scottish-cervical-screening-programme-statistics-annual-update-to-31-march-2021/

- Scottish Bowel Screening Programme Statistics:
  https://publichealthscotland.scot/publications/scottish-bowel-screening-programme-statistics/scottish-bowel-screening-programme-statistics-for-the-period-of-invitations-from-may-2019-to-april-2021/

- Scottish Abdominal Aortic Aneurysm Screening Programme Statistics:
  https://www.publichealthscotland.scot/publications/scottish-abdominal-aortic-aneurysm-aaa-screening-programme-statistics/scottish-abdominal-aortic-aneurysm-aaa-screening-programme-statistics-year-ending-31-march-2021/

- Scottish Diabetic Eye Screening Programme:
  (Data not published).

- Scottish Pregnancy and Newborn Screening:
  https://www.publichealthscotland.scot/publications/births-in-scottish-hospitals/births-in-scottish-hospitals-year-ending-31-march-2021/

  (Programme specific pregnancy and newborn data not published)

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Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Medical Education Annual Report 2021/2022**
Responsible Executive:	**Dr Chris McKenna, Executive Medical Director and Responsible Officer NHS Fife**
Report Authors:	**Prof Morwenna Wood, Director of Medical Education, Dr Kim Steel, Associate Director of Medical Education, Sophie Ali, Medical Education Services Manager**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The General Medical Council (GMC) have developed "Promoting excellence: standards for medical education and training" which became effective on 1 January 2016. NHS Fife is assessed as a Local Education Provider by these standards for medical students and doctors in training on placement.

Requirement 2.2 states:

Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.

The Medical Education Annual Report provides an overview of:

- Key Medical Education activity for context and noting;
- The results of the NHS Education for Scotland (NES) Undergraduate Survey 2021/2022 for assurance; and
- The results of the NHS Education for Scotland (NES) Postgraduate Survey 2021/2022 for assurance

2.2 Background

Undergraduate Medical Education

NHS Fife hosts medical students from the Universities of Edinburgh, Dundee, St Andrews and Aberdeen in order for them to gain experience and receive teaching in a clinical setting. The Medical Education Department is accountable for the quality of teaching delivered.

Postgraduate Medical Education

NHS Fife has approximately 244 Deanery approved doctor-in-training posts that are part of regional and national training programmes. Supervision of doctors-in-training is carried out by recognised trainers in NHS Fife who must produce evidence of continued development and this role is examined as part of the appraisal process.

2.3 Assessment

Undergraduate Survey 2021/2022
Every year, NHS Education Scotland (NES) produce the undergraduate teaching report. The results of the 2021/2022 survey reported a high number of green flags, providing assurance that the quality of undergraduate education carried out in NHS Fife is excellent – see 2021/2022 Undergraduate Teaching Report in appendix 1 in the Medical Education Annual Report.

The annual Director of Medical Education Report, which is submitted to NES, provides an overall summary of undergraduate activity in the previous academic year. The report outlines any known issues and good practice.

Post Graduate Survey 2021/2022
Every year, the General Medical Council (GMC) coordinates the postgraduate survey and the results are available online to the public. This survey had around 600 responses from trainee doctors that had rotated through Fife. The results from the Scottish Training Survey 2021/2022 are set out in appendix 2 in the Medical Education Annual Report.

2.3.1 Quality/ Patient Care

High quality training is fundamental to ensure sufficient numbers of doctors are trained in Scotland.

2.3.2 Workforce

The delivery of medical education by clinicians is in addition to their direct clinical care activities. Having realistic time in job plans is essential and commitment for this is required

by Clinical Directors. A reduction in the trainee cohort would have significant consequences for many departments.

The Medical Education department is involved in widening access to medicine programs in conjunction with St Andrews. These programs prioritise Fife school pupils in the summer after 5th year of secondary school and during the Easter holidays of 6th year to give them work experience in the NHS. This year there has been over 70 week-long placements over the summer and over 60 pupils through the Easter sessions. It is hoped this improves access to health care careers from schools.

There is an increase in international medical graduates (IMG) joining the organisation. The medical education team have developed a program to welcome IMGs to Fife and ensure that they are orientated to practice in the UK. It is hoped that this approach encourages IMGs to make Fife their new home and join the medical workforce in the longer term.

2.3.3 Financial

Participation in undergraduate medical education attracts funding from NHS Education Scotland and generates income for the Board. NES provides the basic salary for all trainees, with the board funding payment for their out of hours work.

2.3.4 Risk Assessment/Management

Key risks and mitigation are as follows:

- NES quality assures education and training in our Board and the DME report is an essential part of the Quality Assurance Framework.
- GMC survey is freely available to the public online and poor survey results risks reputational damage.
- Lack of space for medical education is becoming an increasing risk; with the current space available the department will not be in a position to fulfil the teaching health board status of becoming an integral part of the ScotCOM programme. There are ongoing discussions with colleagues in the Property and Asset Management Department.

2.3.5 Equality and Diversity, including health inequalities

Access to medical education is subject to robust equality and diversity protocols, including an initiative to widen access to medical school places from low income families.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

When the results of the Undergraduate Teaching Report and the Scottish Training Survey are released they are shared with key clinical stakeholders for their information and action. The Medical Education Committee will meet in November 2022 where results will be reviewed by key educators.

2.3.8 Route to the Meeting

This paper has been developed through engagement with the Medical Education Senior Leadership Team.

2.4 Recommendation

The Clinical Governance Committee is recommended to:

- Examine and consider the content of this report; and
- Take **assurance** in relation the approach taken to ensure the delivery of high quality medical education in NHS Fife

3 List of appendices

The following appendices are included within the Medical Education Annual Report:

- Appendix No 1, 2021/22 Undergraduate Teaching Report
- Appendix No 2, Scottish Training Survey 2022

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Medical Education Annual Report

2021/2022

Contents

Medical Education Annual Report 2021/2022

The purpose of this report is to provide assurance to the NHS Fife Clinical Governance Committee. It will provide an overview of:

- Key Medical Education activity for context and noting;
- The results of the NHS Education for Scotland (NES) Undergraduate Survey 2021/2022 for assurance; and
- The results of the NHS Education for Scotland (NES) Postgraduate Survey 2021/2022 for assurance

Introduction

The General Medical Council (GMC) have developed *"Promoting excellence: standards for medical education and training"* which became effective on 1 January 2016. NHS Fife is assessed as a Local Education Provider by these standards for medical students and doctors in training on placement.

Requirement 2.2 states: "*Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns*."

Background

1. Undergraduate Medical Education

The Universities of Edinburgh, Dundee, St Andrews and Aberdeen place medical students with NHS Fife in order for them to gain experience and receive teaching in a clinical setting. The numbers of students has remained fairly consistent until recently. For the 2022 intake there is an increase in student numbers which are detailed below:

University / Programme	2022-23 Student Numbers Increase per week	Breakdown
Edinburgh	13	+6 per week (Year 4) +7 per week (Assistantships)
Dundee	7	+6 per block (Surgery) -3 per block (Surgical Specialties) +4 per block (Medicine)
St Andrews	30 (Approx. Figure)	Based on Semester 1 timetable 2021-2022 average placements per week were 54 compared to 84 student placements this year for Semester 1

ScotGEM	21	Additional 15 requested by the Scottish Govt. 6 re-sits for year 1
Total increase in student numbers	**71**	

The number of students on placement throughout the year will be approximately:

- 235 from Edinburgh
- 130 from Dundee
- 175 from St Andrews
- 104 from the Scottish Graduate Entry Medicine programme (ScotGEM)
- 25 from Aberdeen

The first intake of ScotGEM students graduated in June 2022. Their success has led to an increase in 55 junior doctors across Scotland. ScotGEM is a partnership venture with the universities of St Andrews, Dundee and Highland & Islands and the Health Boards of Dumfries & Galloway, Highland, Tayside and Fife. Year 1, which began in August 2018, has been taught in primary care by GPs called Generalist Clinical Mentors (GCM). NHS Fife currently employs 10 year 1 GCMs (with 1 vacancy), 4 year 2 GCMs (with 1 vacancy), 2 year 3 GCMs, a Deputy Lead GCM and a Lead GCM. These GPs bring 38 clinical sessions to NHS Fife.

This year has seen the partnership working between NHS Fife and the University of St Andrews collaborate to develop a 5 year MBChB programme following on from the recent Scottish Government decision to restore Primary Medical Qualification (PMQ) awarding status to the University of St Andrews. The programme will be tailored to the needs of the NHS in Scotland and will concentrate on delivering community-based medical education that will respond to Scottish Government's priorities. The new programme will be called Scottish Community Orientated Medicine (ScotCOM). Planning is in relatively early stages with working groups being set up to drive this innovative and exciting programme forward.

2. Postgraduate Medical Education

NHS Fife has approximately 244 Deanery approved doctor-in-training posts that are part of regional and national training programmes:

- 78 Foundation Doctors
- 43 Core Trainees
- 44 General Practice Trainees
- 79 further trainees in a range of specialties

The supervision of doctors in training is carried about by the consultant and specialty doctor workforce. There are approximately 210 recognised trainers in the organisation that all require to produce evidence of continued development and this role is examined as part of the appraisal process.

3. Other Developments

Medical Education recognises the importance of multi-disciplinary working and education for medical students and trainee doctors. The department has recently invested a significant amount of endowment funds into the NHS Fife Simulation Training Centre based at Queen Margaret Hospital. The staff managing and facilitating the training sessions are ACT funded. The Training Centre has already seen multi-disciplinary training sessions delivered from Midwives, Nurses, Scottish Ambulance Services, Pharmacists and Allied Health Professionals.

There is a strategic ambition of the Board to attain Teaching Health Board Status. Medical Education is key to this and it is only through supporting the current university partnerships and strengthening the partnership with St Andrews University that this can be achieved.

Evaluation

1. Undergraduate Survey 2021/2022

NHS Education Scotland (NES) produce the undergraduate survey. The results of the 2021/2022 survey reported a high number of green flags, providing assurance that the quality of undergraduate education carried out in NHS Fife is excellent – see 2021/2022 Undergraduate Teaching Report attached in *appendix 1*.

Positive feedback received from all universities is due to the dedication, enthusiasm and commitment that NHS Fife Local Module Leads have towards undergraduate medical education. This can be seen as a number of COVID innovations were introduced to ensure that education could still go ahead for medical students. Examples of these innovations include having our Undergraduate Co-ordinators look across the board to determine student numbers in each ward, limiting access on certain days to allow a certain group of students more exposure to that area; further use of sim ward teaching to increase teaching capacity; linking teaching across degree programmes; and introducing escape room scenarios.

This year there were around 750 student responses providing feedback for the specialty they were placed in. Areas of good practice were identified in General Medicine by both Dundee and Edinburgh students. Similarly, Palliative Care placements by St Andrews and ScotGEM students were rated very highly. Areas of development were noted for IT equipment for ScotGEM students; we are working with Digital and Information colleagues to improve this. There was an area of improvement identified for the block organisation of Respiratory Medicine following

feedback from ScotGEM students. The Medical Education department will work closely with the faculty lead to identify any issues and offer support for organisation for the upcoming year.

The annual Director of Medical Education Report, which is submitted to NES, provides an overall summary of undergraduate activity in the previous academic year. The report outlines good practice as well as actions put in place to address known issues.

2. Post Graduate Survey 2021/2022

The General Medical Council (GMC) coordinates the postgraduate survey and the results are available online to the public. This survey had around 600 responses from trainee doctors that had rotated through Fife. The results from the Scottish Training Survey 2021/2022 are set out in *appendix 2*.

The report highlighted areas of good practice in the following areas:

Urology – the department were praised for adapting training needs for each individual trainee. Trainees are supported through positive feedback and encouraged to attend meetings, such as M&M meetings, to be used as learning opportunities. The department work hard to achieve a balance of training with service commitments.

ICM – the department make use of their multi-professional team to provide a supportive training environment for their trainees. ICU allows for 1:1 out of hours opportunities alongside consultants which provides a lot of hands-on exposure but with sufficient supervision and support. Trainees are provided with weekly opportunities for direct teaching from consultants and are invited to attend weekly team meetings where there are opportunities for education and feedback.

Emergency Medicine – the department provide a bespoke induction for their trainees, they encourage feedback on an ad-hoc basis as well as during Educational Supervisor sessions, and they continue to build on training provided in the department. The department have done a great deal of work to reduce burn out and improve the working day for the trainees.

Positive feedback will be celebrated and good practice can be shared.

Areas requiring improvement were noted from Acute Internal Medicine. The Director of Medical Education will work with the relevant Clinical Leads in order to develop improvement plans to address any issues This year's feedback reflects a number of challenges that medicine has been experiencing in view of the challenges of the pandemic. In particular, covid admissions and related issues with workforce sick leave with covid, rota gaps and exhaustion across our workforce. We need to strengthen the medical induction as it has been the same for a few years; maybe to include a hospital tour and more interactivity. Improvement work has been

implemented for handover practice for medical specialities and a post ward round huddle has been introduced; we maybe need to restructure the verbal handovers. We started a project last year with the aim of getting the trainees individual feedback more often, in an organised way; this remains work in progress. It important to note that education supervision has maintained a good score as has the score for supportive environment, despite the pressures. Any improvements will be co-designed with trainees with support through the Chief Registrar programme.

NHS Fife strives to offer excellent postgraduate training thanks to the commitment of all educators. It is important to note that Medical Education do not receive funding for postgraduate trainee doctors and rely on funding from the Board. It is essential that there is commitment from Clinical Directors that Consultants have dedicated time in their SPA for education, training and supervision. Workload pressures may prevent trainees achieving requirements of training such as Quality Improvement projects, simulation training, and leadership opportunities.

List of appendices

The following appendices are included with this report:

- Appendix No 1, 2021/22 Undergraduate Teaching Report
- Appendix No 2, Scottish Training Survey 2022

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Appendix 1 – 2021/22 Undergraduate Teaching Report

NHS Education for Scotland

2021/22 Detailed Undergraduate Teaching Report: NHS Fife

School	Site	Specialty	Year	Overall Satisfaction	Block Organisation	Treated With Respect	Teaching Delivery	Teaching Quality	Total: Teaching	Learning Opportunities	Clinical Experience	Total: Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total: Support	IT Equipment	Access to Software	Total: IT	Teaching Equipment	Teaching Accommodation	Total: Facilities	Number of respondents
ScotGEM	Adamson Hospital	Paediatrics	2																						1 (5)
St Andrews	Cameron Hospital	Rehabilitation Medicine	3	▬	▬													▬							6 (19)
ScotGEM	Glenwood Health Centre	Paediatrics	2																						2 (10)
ScotGEM	NHS Fife	Secondary Care - second semester	4																						10 (10)
Dundee	NHS Fife	SSC	5																						6 (16)
ScotGEM	Queen Margaret Hospital	Antenatal Clinic	2																						4 (16)
St Andrews	Queen Margaret Hospital	Breast Surgery	3																						17 (68)
ScotGEM	Queen Margaret Hospital	Dermatology	2																						58 (110)
ScotGEM	Queen Margaret Hospital	General Psychiatry	2																						23 (4)
ScotGEM	Queen Margaret Hospital	Medicine of the Elderly	2																						9 (36)
ScotGEM	Queen Margaret Hospital	Obstetrics & Gynaecology	2																						11 (30)
St Andrews	Queen Margaret Hospital	Ophthalmology	3																						2 (20)
ScotGEM	Queen Margaret Hospital	Ophthalmology	2																						14 (43)
ScotGEM	Queen Margaret Hospital	Orthopaedics	2																						1 (12)
Edinburgh	Queen Margaret Hospital	Psychiatry	5																						1 (2)
ScotGEM	Queen Margaret Hospital	Simulation	2																						14 (28)
St Andrews	Queen Margaret Hospital	Simulation and Examination	3																						8 (66)
Dundee	Queen Margaret Hospital	SSC	5																						1 (5)
ScotGEM	St Andrews Community Hospital	Urgent Care	2																						3 (16)
ScotGEM	Stratheden Hospital	General Psychiatry	2																						2 (3)
St Andrews	Stratheden Hospital	Old Age Psychiatry	3																						4 (21)
Dundee	Stratheden Hospital	Psychiatry	4																						3 (20)
Edinburgh	Stratheden Hospital	Psychiatry	5																						4 (4)
Dundee & ScotGEM	Victoria Hospital	Anaesthetics	D5/S4																						1 (8)
ScotGEM	Victoria Hospital	Antenatal Clinic	2																						12 (20)
Dundee	Victoria Hospital	Child Health	4	▲	▲		▲	▬	▲	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	6 (35)
Edinburgh	Victoria Hospital	Child Life and Health	5	▲	▲			▲		▲						▬	▬	▬	▬	▬	▬				10 (12)
St Andrews	Victoria Hospital	Clinical Reasoning	3																						29 (104)
St Andrews	Victoria Hospital	Dermatology	3																						5 (16)
ScotGEM	Victoria Hospital	Diabetes	2																						4 (14)
St Andrews	Victoria Hospital	Emergency Medicine	3																						18 (60)
ScotGEM	Victoria Hospital	Emergency Medicine	2																						8 (84)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes

This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown regardless of the number of responses available. Figures in brackets are the potential number of respondents. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Trend data: ▲ indicates an improvement in the flag from the previous year, ▼ a deterioration and ▬ no change.

2021/22 Detailed Undergraduate Teaching Report: NHS Fife

NHS Education for Scotland

School	Site	Specialty	Year	Overall Satisfaction	Blog Organisation	Treated With Respect	Teaching Delivery	Teaching Quality	Total: Teaching	Learning Opportunities	Clinical Experience	Total: Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total: Support	IT Equipment	Access to Software	Total: IT	Teaching Equipment	Teaching Accommodation	Total: Facilities	Number of respondents
ScotGEM	Victoria Hospital	Gastroenterology	2																						15 (34)
St Andrews	Victoria Hospital	Gastrointestinal	3																						2 (19)
Dundee	Victoria Hospital	General Medicine	4	—	—		—	—	—	—	—	—	—	▲	▲	—	—	—	▼	—	—	—	▲	▲	7 (33)
Dundee	Victoria Hospital	General Surgery	4																						5 (10)
ScotGEM	Victoria Hospital	General Surgery	2																						13 (22)
ScotGEM	Victoria Hospital	Hub	2																						4 (26)
Dundee	Victoria Hospital	Intensive Care Medicine	5																						2 (9)
St Andrews	Victoria Hospital	Loss	3	—	▲			—	—		▼						—	—							35 (114)
ScotGEM	Victoria Hospital	Medical Orthopaedics	2																						10 (22)
St Andrews	Victoria Hospital	Medicine of the Elderly	3																						17 (55)
St Andrews	Victoria Hospital	Neurology	3																						2 (3)
Dundee	Victoria Hospital	Obstetrics & Gynaecology	4																						4 (30)
Edinburgh	Victoria Hospital	Obstetrics and Gynaecology	5	▼	▲			▲		▲						—	—	—	—	—	—				10 (10)
St Andrews	Victoria Hospital	Orthopaedics	3	—	—			—	—		—						▼								34 (117)
ScotGEM	Victoria Hospital	Orthopaedics	2																						10 (14)
St Andrews	Victoria Hospital	Paediatric Physiotherapy	3																						4 (12)
Dundee	Victoria Hospital	Paediatrics	5																						2 (13)
ScotGEM	Victoria Hospital	Paediatrics	2																						42 (129)
St Andrews	Victoria Hospital	Palliative Care	3																						25 (58)
ScotGEM	Victoria Hospital	Palliative Medicine	2																						20 (28)
St Andrews	Victoria Hospital	Peri-operative Care	3																						13 (47)
ScotGEM	Victoria Hospital	Rehabilitation Medicine	2																						17 (30)
Edinburgh	Victoria Hospital	Renal	5																						11 (22)
ScotGEM	Victoria Hospital	Renal Medicine	2																						3 (16)
St Andrews	Victoria Hospital	Reproductive Health	3																						20 (64)
ScotGEM	Victoria Hospital	Respiratory Medicine	2																						9 (24)
Edinburgh	Victoria Hospital	Senior Medicine	6	—	—			—		▲						▲	—	▲	—	—	—				19 (43)
St Andrews	Victoria Hospital	Sexual Health	3																						10 (45)
Edinburgh	Victoria Hospital	Specialties and Ward Based Medicine	4																						13 (18)
Dundee	Victoria Hospital	SSC	5																						3 (8)
St Andrews	Victoria Hospital	Surgery	3	—	—			—			—						▼								14 (61)
Dundee	Victoria Hospital	Surgery Specialties - Ophthalmology	4																						4 (28)

Undergraduate

- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes

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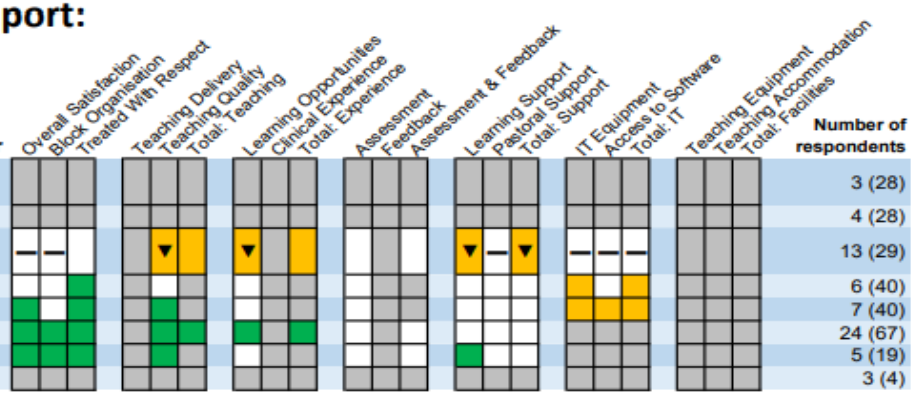
2021/22 Detailed Undergraduate Teaching Report: NHS Fife



School	Site	Specialty	Year	Number of respondents
Dundee	Victoria Hospital	Surgery Specialties - Otolaryngology	4	3 (28)
Dundee	Victoria Hospital	Surgery Specialties - Urology	4	4 (28)
Edinburgh	Victoria Hospital	Surgery/Anaesthesia/Critical Care	6	13 (29)
ScotGEM	Victoria Hospital	Urgent Care	2	6 (40)
ScotGEM	Victoria Hospital	Urology	2	7 (40)
St Andrews	Victoria Hospital	When Organs Fail	3	24 (67)
St Andrews	Whytemans Brae Hospital	ENT	3	5 (19)
Edinburgh	Whytemans Brae Hospital	Psychiatry	5	3 (4)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes
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Appendix 2 – Scottish Training Survey 2022

NHS Education for Scotland

Scottish Training Survey 2022

NHS Fife

Green	Performing well for this indicator
Lime	Performing above average for this indicator
White	Performing is about average for this indicator
Pink	Performing below average for this indicator
Red	Performing poorly in this indicator
Grey	N<3
▲	Significant improvement in mean score since previous year
▼	Significant deterioration in mean score since previous year
—	No significant change in mean score

Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
Acute Internal Medicine	Victoria Hospital	Core	—	—	—	—	—	—	—	6
Acute Internal Medicine	Victoria Hospital	IMT								6
Acute Internal Medicine	Victoria Hospital	ST								1
Acute Internal Medicine	*Victoria Hospital*	*ST*	—	—	—		—	—	—	*3*
Anaesthetics	Victoria Hospital	Core	▲	—	—	—	—	—	—	8
Anaesthetics	Victoria Hospital	Foundation	—	▲	—	—	—	—	—	3
Anaesthetics	Victoria Hospital	ST	—	▼	—	—	—	—	—	11
Cardiology	*Victoria Hospital*	*Core*								*1*
Cardiology	*Victoria Hospital*	*Foundation*								*1*
Cardiology	Victoria Hospital	IMT								2
Cardiology	*Victoria Hospital*	*IMT*								*2*
Cardiology	Victoria Hospital	ST								1
Cardiology	*Victoria Hospital*	*ST*								*2*
Child & Adolescent Psychiatry	*Lynebank Hospital*	*ST*								*1*
Child & Adolescent Psychiatry	Stratheden Hospital	Core								2
Child & Adolescent Psychiatry	*Stratheden Hospital*	*Core*	—	—	—	—	—	—	—	*4*
Child & Adolescent Psychiatry	Stratheden Hospital	ST								1
Child & Adolescent Psychiatry	*Stratheden Hospital*	*ST*								*2*
Clinical Radiology	*Queen Margaret Hospital*	*ST*								*1*
Clinical Radiology	Victoria Hospital	ST								1
Clinical Radiology	*Victoria Hospital*	*ST*								*2*
Colorectal Surgery	*Victoria Hospital*	*ST*								*2*
Community Health	*Queen Margaret Hospital*	*ST*								*1*

The methodology used to create these reports is explained in the non-technical and technical reports. The results are benchmarked against the results from trainees at a similar level of training in corresponding specialties, these are set out in the list of benchmark groups. "Significant Change Indicators" (▲ or ▼) show a 95% significant change in the mean score for a unit and do not indicate a change in outcome.
Rows in italics and coloured blue contain aggregated 2020 to 2022 results.

NHS Education for Scotland

Scottish Training Survey 2022
NHS Fife

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Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
Dermatology	*Queen Margaret Hospital*	*GPST*								*1*
Dermatology	*Queen Margaret Hospital*	*ST*								*1*
Dermatology	Victoria Hospital	GPST								2
Dermatology	*Victoria Hospital*	*GPST*								*2*
Dermatology	*Victoria Hospital*	*ST*								*1*
Emergency Medicine	Victoria Hospital	Foundation	▲	—	—	▲	—	▲	▲	12
Emergency Medicine	Victoria Hospital	GPST	—	—	—	▲	—	—	—	7
Emergency Medicine	Victoria Hospital	ST	—	—	—	—	—	—	—	8
Endocrinology and Diabetes Mellitus	*Victoria Hospital*	*Core*								*1*
Endocrinology and Diabetes Mellitus	Victoria Hospital	IMT								2
Endocrinology and Diabetes Mellitus	*Victoria Hospital*	*IMT*	—	—	—	—	—	—	—	*5*
Endocrinology and Diabetes Mellitus	*Victoria Hospital*	*ST*								*1*
Forensic Psychiatry	Stratheden Hospital	Core								2
Forensic Psychiatry	*Stratheden Hospital*	*Core*	—	—	—	—	—	—	—	*4*
Forensic Psychiatry	Stratheden Hospital	ST								1
Forensic Psychiatry	*Stratheden Hospital*	*ST*								*1*
Gastroenterology	*Victoria Hospital*	*Foundation*								*1*
General (Internal) Medicine	Victoria Hospital	Foundation	—	—	—	—	—	—	▲	54
General (Internal) Medicine	Victoria Hospital	GPST								2
General (Internal) Medicine	*Victoria Hospital*	*GPST*	—	—	—	—	—	—	—	*5*
General (Internal) Medicine	Victoria Hospital	IMT	—	—	—	—	—	—	—	7
General (Internal) Medicine	Victoria Hospital	ST	—	—	—	—	—	—	—	3
General Practice	Airlie Medical Practice	GPST								1

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Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
General Practice	*Airlie Medical Practice*	*GPST*	—	—		—	—	—	—	*3*
General Practice	Bank Street Medical Group	GPST								2
General Practice	*Bank Street Medical Group*	*GPST*	—	—	—	—	—	—	—	*5*
General Practice	Bennochy Medical Centre	Foundation								1
General Practice	*Bennochy Medical Centre*	*Foundation*	—	—	—	—	—	—	—	*5*
General Practice	Bennochy Medical Centre	GPST								3
General Practice	Blackfriars Medical Practice	GPST								1
General Practice	*Blackfriars Medical Practice*	*GPST*								*3*
General Practice	Cos Lane Surgery	GPST								1
General Practice	*Cos Lane Surgery*	*GPST*	—	—		—	—	—	—	*3*
General Practice	Cowdenbeath Surgery	GPST								1
General Practice	*Cowdenbeath Surgery*	*GPST*	—	—		—	—	—	—	*3*
General Practice	Inverkeithing Medical Group	GPST								2
General Practice	*Inverkeithing Medical Group*	*GPST*								*3*
General Practice	Kelty Medical Practice	GPST								2
General Practice	*Kelty Medical Practice*	*GPST*	—	—	—	—	—	—	—	*5*
General Practice	Markinch Medical Practice	GPST								1
General Practice	*Markinch Medical Practice*	*GPST*								*2*
General Practice	Muiredge Surgery	GPST								1
General Practice	*Muiredge Surgery*	*GPST*								*1*
General Practice	Nethertown Surgery	GPST								2
General Practice	*Nethertown Surgery*	*GPST*	—	—		—	—	—	—	*4*
General Practice	New Park Medical Practice	Foundation								2

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NHS Fife

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Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
General Practice	*New Park Medical Practice*	*Foundation*	—	—	—	—	—	—	—	*6*
General Practice	New Park Medical Practice	GPST								1
General Practice	*New Park Medical Practice*	*GPST*	—	—		—	—	—	—	*3*
General Practice	Pipeland Medical Practice	Foundation								1
General Practice	*Pipeland Medical Practice*	*Foundation*								*1*
General Practice	Pipeland Medical Practice	GPST								2
General Practice	*Pipeland Medical Practice*	*GPST*	—	—		—	—	—	—	*7*
General Practice	Pitcairn Practice Leuchars & Balmullo	GPST								1
General Practice	*Pitcairn Practice Leuchars & Balmullo*	*GPST*								*1*
General Practice	*Primrose Lane Medical Centre*	*GPST*								*2*
General Practice	St Brycedale Surgery	GPST								1
General Practice	*St Brycedale Surgery*	*GPST*								*3*
General Practice	The Glenwood Practice	GPST								1
General Practice	*The Glenwood Practice*	*GPST*	—	—		—	—	—	—	*5*
General Practice	The Lomond Practice	GPST								1
General Practice	*The Lomond Practice*	*GPST*	—	—		—	—	—	—	*3*
General Psychiatry	Queen Margaret Hospital	Core								1
General Psychiatry	*Queen Margaret Hospital*	*Core*	—	—	—	—	—	—	—	*4*
General Psychiatry	Queen Margaret Hospital	GPST								2
General Psychiatry	*Queen Margaret Hospital*	*GPST*	—	—	—	—	—	—	—	*4*
General Psychiatry	Queen Margaret Hospital	ST								1
General Psychiatry	*Queen Margaret Hospital*	*ST*	—	—	—	—	—	—	—	*3*
General Psychiatry	Stratheden Hospital	Core	—	▼	▼	—	▼	▼	▼	4

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NHS Fife

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Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
General Psychiatry	Stratheden Hospital	Foundation								1
General Psychiatry	*Stratheden Hospital*	*Foundation*	—	—	—	—	—	—	—	*6*
General Psychiatry	Stratheden Hospital	GPST								2
General Psychiatry	*Stratheden Hospital*	*GPST*								*3*
General Psychiatry	*Stratheden Hospital*	*ST*								*2*
General Psychiatry	*Victoria Hospital*	*GPST*								*1*
General Psychiatry	Whytemans Brae Hospital	Core								2
General Psychiatry	*Whytemans Brae Hospital*	*Core*	—	—	—	—	—	—	—	*4*
General Psychiatry	*Whytemans Brae Hospital*	*Foundation*								*1*
General Psychiatry	Whytemans Brae Hospital	GPST								3
General Surgery	Victoria Hospital	Core								2
General Surgery	*Victoria Hospital*	*Core*	—	—	—	—	—	—	—	*10*
General Surgery	Victoria Hospital	Foundation	—	—	—	—	—	—	—	40
General Surgery	Victoria Hospital	ST	—	▲	—	—	▲	—	—	7
Geriatric Medicine	*Queen Margaret Hospital*	*Foundation*								*1*
Geriatric Medicine	*Queen Margaret Hospital*	*GPST*								*1*
Geriatric Medicine	Victoria Hospital	Foundation	—	▼	—	—	—	▼	—	4
Geriatric Medicine	Victoria Hospital	GPST	—	—	—	—	—	—	—	16
Geriatric Medicine	Victoria Hospital	IMT	—	—	—	—	▼	—	▲	6
Geriatric Medicine	Victoria Hospital	ST								2
Geriatric Medicine	*Victoria Hospital*	*ST*	—	—	—		—	—	—	*4*
Geriatric Medicine	*Whytemans Brae Hospital*	*Foundation*								*1*
Haematology	*Victoria Hospital*	*Foundation*								*1*

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NHS Education for Scotland

Scottish Training Survey 2022

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▼	Significant deterioration in mean score since previous year
—	No significant change in mean score

Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
Haematology	Victoria Hospital	ST								2
Haematology	*Victoria Hospital*	*ST*	—	—	—	—	—	—	—	*5*
Histopathology	Victoria Hospital	ST								2
Histopathology	*Victoria Hospital*	*ST*	—	—			—	—		*5*
Intensive Care Medicine	Victoria Hospital	Core								2
Intensive Care Medicine	*Victoria Hospital*	*Core*	—	—	—	—	—	—	—	*4*
Intensive Care Medicine	Victoria Hospital	IMT	—	—	—	—	—	—	—	7
Intensive Care Medicine	Victoria Hospital	ST	—	▲	▲	—	▲	—	▲	3
Neonatal Medicine	*Victoria Hospital*	*ST*								*2*
Obstetrics and Gynaecology	Victoria Hospital	Foundation	—	—	—	—	—	—	—	3
Obstetrics and Gynaecology	Victoria Hospital	GPST	—	—	—	—	—	—	—	8
Obstetrics and Gynaecology	Victoria Hospital	ST	—	—	—	—	—	—	—	6
Obstetrics and Gynaecology	Victoria Maternity Unit	ST								4
Old Age Psychiatry	Queen Margaret Hospital	Core								2
Old Age Psychiatry	*Queen Margaret Hospital*	*Core*	—	—	—		—	—	—	*4*
Old Age Psychiatry	Queen Margaret Hospital	Foundation								1
Old Age Psychiatry	*Queen Margaret Hospital*	*Foundation*								*2*
Old Age Psychiatry	*Queen Margaret Hospital*	*GPST*								*2*
Old Age Psychiatry	*Stratheden Hospital*	*Core*								*1*
Old Age Psychiatry	Stratheden Hospital	Foundation								2
Old Age Psychiatry	*Stratheden Hospital*	*Foundation*	—	—	—	—	—	—	—	*5*
Old Age Psychiatry	Whytemans Brae Hospital	ST								1
Old Age Psychiatry	*Whytemans Brae Hospital*	*ST*	—	—	—	—	—	—	—	*3*

The methodology used to create these reports is explained in the non-technical and technical reports. The results are benchmarked against the results from trainees at a similar level of training in corresponding specialties, these are set out in the list of benchmark groups. "Significant Change Indicators" (▲ or ▼) show a 95% significant change in the mean score for a unit and do not indicate a change in outcome.
Rows in italics and coloured blue contain aggregated 2020 to 2022 results.

NHS Education for Scotland

Scottish Training Survey 2022

NHS Fife

Green	Performing well for this indicator
Lime	Performing above average for this indicator
White	Performing is about average for this indicator
Pink	Performing below average for this indicator
Red	Performing poorly in this indicator
Grey	N<3
▲	Significant improvement in mean score since previous year
▼	Significant deterioration in mean score since previous year
—	No significant change in mean score

Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
Ophthalmology	Queen Margaret Hospital	GPST								1
Ophthalmology	*Queen Margaret Hospital*	*GPST*	—	—	—	—	—	—	—	*3*
Ophthalmology	Queen Margaret Hospital	ST	—	—	—	—	—	—	—	7
Otolaryngology	Victoria Hospital	GPST	—	—	—	—	—	—	—	4
Otolaryngology	Victoria Hospital	ST								1
Otolaryngology	*Victoria Hospital*	*ST*	—	—	—	—	—	—	—	*5*
Paediatrics	Victoria Hospital	Foundation	—	—	—	—	—	—	—	4
Paediatrics	Victoria Hospital	GPST	—	▼	—	—	▼	▼	—	13
Paediatrics	Victoria Hospital	ST	—	—	—	—	▼	▼	▼	9
Palliative medicine	*Queen Margaret Hospital*	*GPST*								*1*
Palliative medicine	Queen Margaret Hospital	ST								1
Palliative medicine	*Queen Margaret Hospital*	*ST*								*1*
Palliative medicine	Victoria Hospital	GPST								2
Palliative medicine	*Victoria Hospital*	*GPST*	—	—	—	—	—	—	—	*5*
Palliative medicine	*Victoria Hospital*	*ST*								*1*
Psychiatry of Learning Disability	Lynebank Hospital	Core								2
Psychiatry of Learning Disability	*Lynebank Hospital*	*Core*	—	—	—	—	—	—	—	*5*
Public health medicine	NHS Fife	ST								2
Public health medicine	*NHS Fife*	*ST*	—	—	—	—	—	—	—	*5*
Renal Medicine	*Victoria Hospital*	*Core*								*2*
Renal Medicine	Victoria Hospital	IMT								2
Renal Medicine	*Victoria Hospital*	*IMT*								*4*
Renal Medicine	*Victoria Hospital*	*ST*								*1*

The methodology used to create these reports is explained in the non-technical and technical reports. The results are benchmarked against the results from trainees at a similar level of training in corresponding specialties, these are set out in the list of benchmark groups. "Significant Change Indicators" (▲ or ▼) show a 95% significant change in the mean score for a unit and do not indicate a change in outcome.
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▼	Significant deterioration in mean score since previous year
—	No significant change in mean score

Post Specialty	Site	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Number of Responses
Respiratory Medicine	*Victoria Hospital*	*Core*								*1*
Respiratory Medicine	*Victoria Hospital*	*Foundation*								*1*
Respiratory Medicine	Victoria Hospital	IMT								5
Trauma and Orthopaedic Surgery	Queen Margaret Hospital	ST								1
Trauma and Orthopaedic Surgery	*Queen Margaret Hospital*	*ST*								*2*
Trauma and Orthopaedic Surgery	*Victoria Hospital*	*Foundation*								*2*
Trauma and Orthopaedic Surgery	Victoria Hospital	ST	—	▲	—	▲	▲	▲	▲	8
Urology	Queen Margaret Hospital	ST								1
Urology	*Queen Margaret Hospital*	*ST*	—	—	—	—	—	—	—	*4*
Urology	*Victoria Hospital*	*Core*								*1*
Urology	*Victoria Hospital*	*Foundation*								*1*
Urology	Victoria Hospital	ST								1
Urology	*Victoria Hospital*	*ST*								*2*

The methodology used to create these reports is explained in the non-technical and technical reports. The results are benchmarked against the results from trainees at a similar level of training in corresponding specialties, these are set out in the list of benchmark groups. "Significant Change Indicators" (▲ or ▼) show a 95% significant change in the mean score for a unit and do not indicate a change in outcome.
Rows in italics and coloured blue contain aggregated 2020 to 2022 results.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Medical Appraisal and Revalidation Annual Report 2021-22**
Responsible Executive:	**Dr Chris McKenna, Medical Director, NHS Fife**
Report Author:	**Alison Gracey, Medical Appraisal and Revalidation Coordinator**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Medical Staff Revalidation and Appraisal report for 2021-2022 is being brought to the Staff Governance Committee for their awareness. The report provides the committee with an assurance that doctors in NHS Fife are up-to-date and are practising to the appropriate professional standards.

2.2 Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3 Assessment

NHS Fife responds well to the challenges of Medical Revalidation and Appraisal with few problems, is managing to meet the requirements of the GMC. Appraisal is getting back on track following the lockdowns due to Covid 19 of 2020/2021. Secondary Care still struggle

to recruit and retain sufficient NES Trained Appraisers and are relying on bank appraisers to fill the gap. Secondary Care continue to advertise the role.

2.3.1 Quality / Patient Care

Medical appraisal ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.2 Workforce

2021/2022 was challenging for all those working in the health and care services, with many appraisals having previously been delayed due to the pandemic.

The national data collection for 2021/2022 was cancelled by National Education Scotland (NES) due to the Covid 19 pandemic. Appraisal figures for the year are noted within the report.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment / Management

There may be a risk of being unable to meet the GMC requirements for Medical Revalidation and Appraisal if unable to recruit and retain sufficient numbers of NES Trained Appraisers.

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

NHS Fife has a Medical Appraisal and Revalidation Group who assesses and implements any changes which need to be made to current system to keep in line with the national enhanced appraisal process.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting and the opportunity for the Responsible Officer to discuss any other issues such as revalidation

2.3.8 Route to the Meeting

- Not applicable

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Medical Appraisal and Revalidation Annual Report 2021-22

Report Contact
Alison Gracey
Medical Appraisal and Revalidation Coordinator, NHS Fife
Email alison.gracey@nhs.scot

NHS Fife

Medical Appraisal and Revalidation Annual Report

Consultants, Career Grade Doctors and General Practitioners

2021/2022

Contents

Medical Appraisal and Revalidation 2021/2022

Consultants, Career Grade Doctors and General Practitioners

Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

Revalidation requires annual appraisal, including feedback from colleagues and patients at least once during the five year period. Evidence of the doctor's range and volume of practice, such as the number of operations carried out or prescribing patterns is also reviewed.

Governance Structure

Every doctor wishing to practise medicine in the UK must be linked to a Designated Body and its' Responsible Officer (RO) referred to as a "prescribed connection". Recommendations for the revalidation of all doctors is achieved through each Health Board's RO.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

In line with national policy Dr Chris McKenna is NHS Fife's Responsible Officer, Dr Helen Hellewell is NHS Fife's Deputy Responsible Officer. This responsibility covers all Consultants, Career Grade Doctors and General Practitioners employed by NHS Fife.

Medical Revalidation in NHS Fife is overseen by the Medical Appraisal and Revalidation Group chaired by Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife. This group reports to NHS Fife's Clinical and Staff Governance Committees.

Annual Appraisal

Revalidation for doctors in Scotland is achieved by using a standardised bespoke "Enhanced Appraisal" system designed by the National Appraisal Leads Group for Scotland (NALG).

All doctors in both Primary Care and Secondary Care are required to participate in an annual appraisal.

Appraisals are documented using the NHS Education Scotland (NES) provided web based system SOAR (Scottish Online Appraisal Resource). A signed Form 4 (appraisal summary) is proof that an individual has successfully engaged in the Appraisal process for that year.

Appraisers

All appraisers in Scotland must be NES trained. In Primary Care there are **15** NHS Fife appointed NES trained Appraisers. This allows every General Practitioner (GP) to have an annual appraisal. GP Appraiser recruitment is undertaken locally.

In Secondary Care there were 41 NES trained appraisers as of 31 March 2022, this is a slight increase from 36 in 2020/2021.

The recruitment and retention of appraisers in Secondary Care can be challenging hence NHS Fife has enlisted the help of a small bank of retired appraisers.

Appraisers in Secondary Care are expected to cover 10 appraisals per year within 0.5 of a Supporting Professional Activity (SPA).

NES have increased the frequency of the appraiser training course with at least 2 courses available per month; however with the pressures on services, it has still been difficult to recruit. The course, previously 2 days held at venues across Scotland, is now 2 half days delivered virtually in combination with e-learning modules.

A revised approach to attracting eligible doctors to undertake appraiser training is being developed.

Impact of Covid 19 Pandemic on Appraisal/Revalidation 2021/2022

Although the appraisal and revalidation process was up and running again following the lockdowns of 2020/2021, there was a knock on affect into 2021/2022. With many doctors playing catch up on delayed appraisals.

Some doctors are still struggling to obtain patient feedback, however the situation is improving as services return to a new normal.

A number of doctors have required a deferral of their revalidation date due to the delays and issues obtaining patient feedback. See Chart 1 for figures.

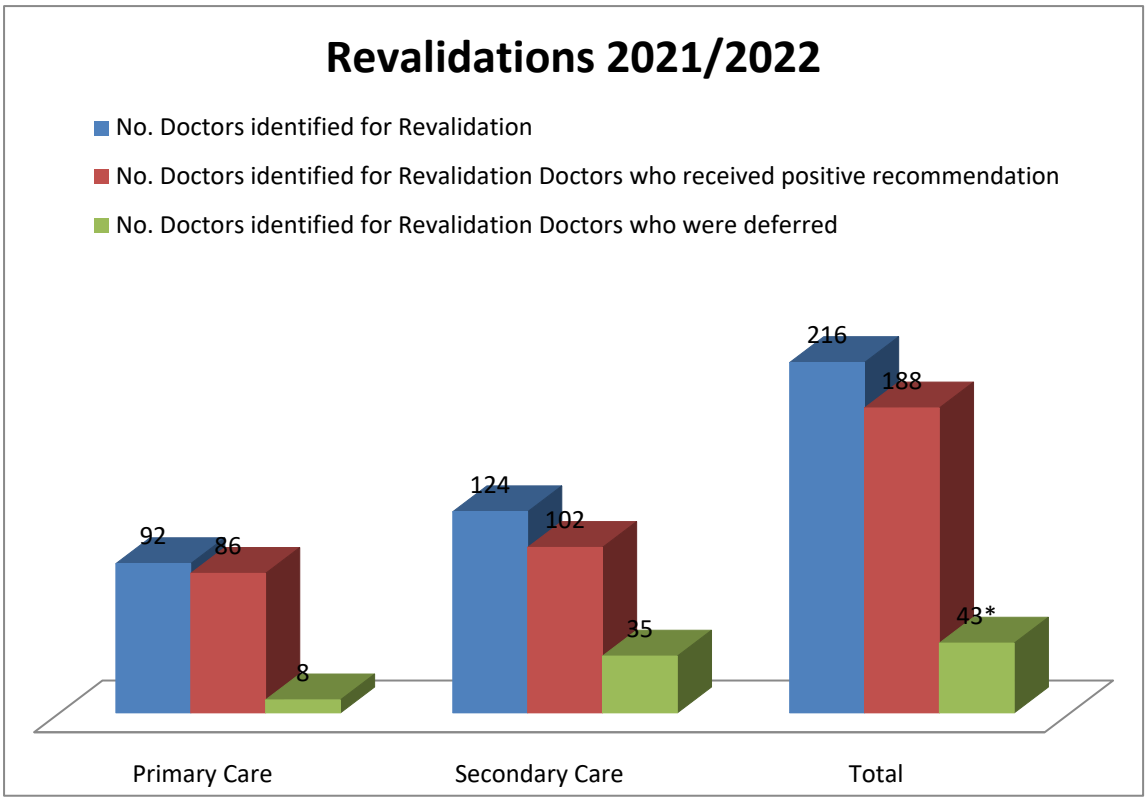

Chart 1: Revalidation 2021/2022

* A total of 15 doctors (2 PC and 13 SC) who were deferred later revalidated in the same period.

Appraisal within NHS Fife for Period 1 April 2021– 31 March 2022

As at 31 March 2022 there were 722 doctors with a prescribed connection to NHS Fife. This includes Primary Care (GP's), Secondary Care (Consultants, SAS Doctors, Clinical Fellows and Honorary Consultants), and University staff without an honorary contract.

The appraisal process is recovering well following the lockdowns of 2020/2021 due to the Covid 19 pandemic. Although the focus still remains on wellbeing and there are some issues gathering certain evidence, we are seeing more and more appraisals returning to pre pandemic levels of evidence. Many more have successfully managed to complete an appraisal during 2021/2022. Numbers and appraisal status for 2021/2022 can be seen in Chart 2 below. Although there are still some delays, there have been far fewer Form 5A's (exemption from appraisal) required in 2021/2022 (See Chart 3).

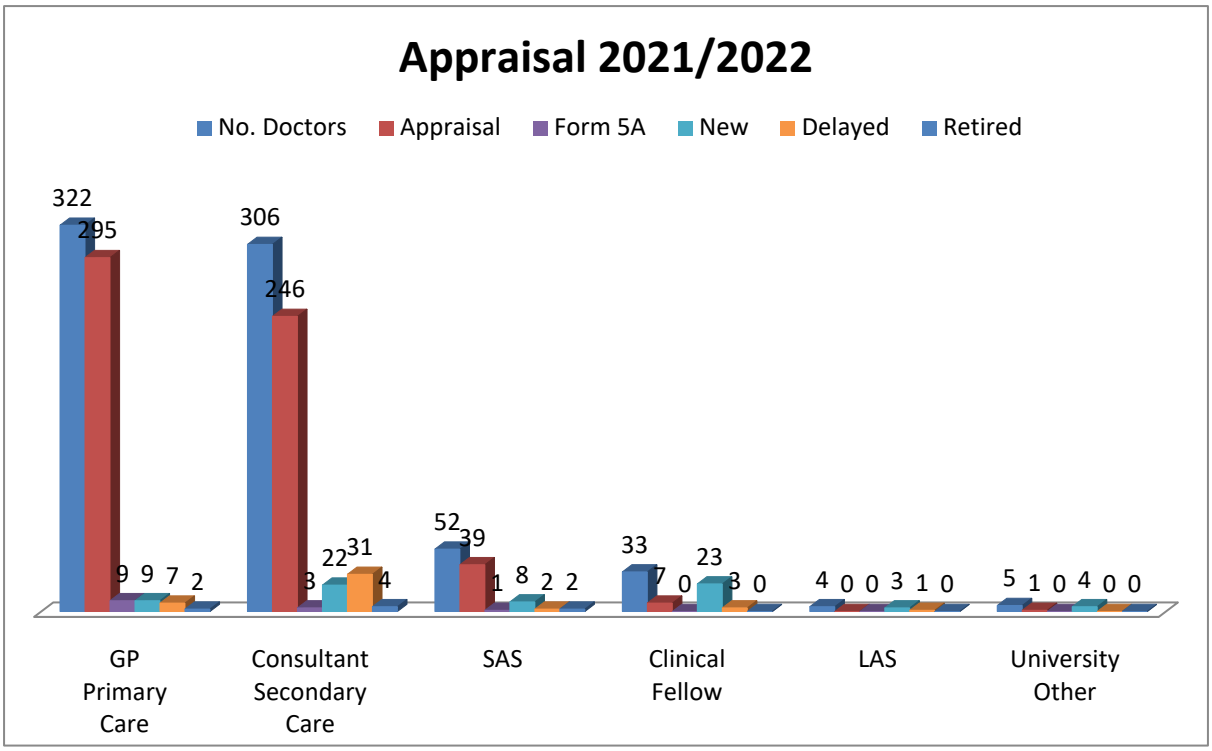

Chart 2: Appraisal 2021/22

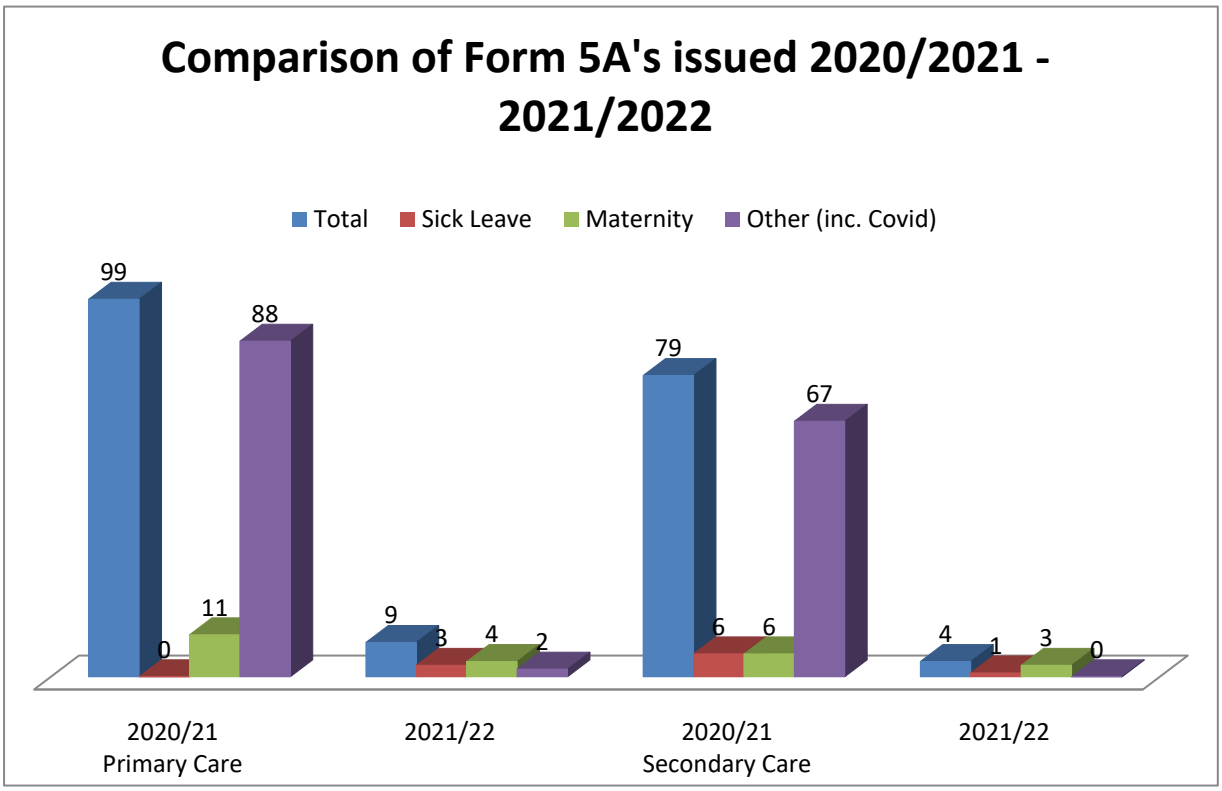

Chart 3: Comparison of Form 5A's Issued 2020/21 – 2021/2022

Summary

The key issues for 2021/2022

1. NHS Fife continues to respond well to the challenges of Medical Appraisal and Revalidation despite the Covid 19 pandemic delays and issues around patient feedback.
2. The GP Appraisal scheme in Fife continues to run well with little or no problems identified therefore no further action is required at this time.
3. The Appraisal process in Secondary Care continues to run well with few problems identified other than recruitment and retention of Appraisers.
4. MARG continues to be instrumental in overseeing the appraisal and revalidation processes and ensuring any issues/challenges that arise are resolved.

The key actions for 2022/2023

1. Continue to maintain an up-to-date record of all Consultants, Career Grade Doctors and General Practitioners with whom NHS Fife has a "prescribed connection".
2. Develop a strategy to encourage the recruitment of trained appraisers within secondary care in NHS Fife. Create a supportive 'myth busting' approach towards appraisal and revalidation in Fife.
3. Continue to support doctors with the appraisal/revalidation process following the Covid 19 pandemic who are having difficulties obtaining patient feedback or getting back on track after significant delays.

Alison Gracey
Medical Appraisal and Revalidation Coordinator
NHS Fife
30 September 2022

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Prevention & Control of Infection Annual Report 2021**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Julia Cook Infection Control Manager**

1 Purpose

Update for NHS Fife Infection Prevention and Control Annual Report 2021 to provide assurance that all IP&C priorities are being, and will be, delivered.

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2021-22),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) Standards (2015)* are included

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:

October 2019: The New standards have been announced by the Scottish Government's Chief Nursing Officer for the reduction of Healthcare Associated Infections for CDI, SAB and ECB. 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 2022, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2022 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 2022, 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 2021/22 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 2022, 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 2021/22 is 33.0 per 100,000 total bed days.

2.3 Assessment

ECB

During the surveillance period of 2021 there was a total of 249 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by urethral catheters. However in hospital acquired ECB, urethral catheters are the second most common source of infection.
- Hospital patients only account for ~20% of the total ECB therefore reducing ECB to achieve the LDP will require infection prevention measures in both the hospital sector and in the Health and Social Care Partnerships.

CDI

NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 5 years. Much improvement work has taken place to ensure a better outcome for patients and service users.

- Between 1st January and 31st December 2021 there were a total of 44 cumulative episodes of CDI in patients aged ≥ 15 years in Fife.
- There were 16 hospital associated infection (HAI) CDI, 9 healthcare associated infections (HCAI) and 3 unknowns. Further to this, 16 CDI infections were community associated infections (CAI).
- Of the 44 cases there were 5 episodes of recurrent CDI, this is the lowest number of recurrent infections since 2016

SAB

- During 2021 in NHS Fife there was a total of 80 SAB.
- Compared to 2020 there has been a 2.4% decrease in the number of SAB. This is the lowest annual total on record.
- In 2021 there were two MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
- The proportion of VADs resulting in a hospital acquired SAB in 2021 was 30%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
- Two SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
- When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug remained stable at 5 episodes in 2021.
- To reduce SAB further focus on; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.
- SAB where the entry point is not known remain a significant problem and accounted for 23.75% percent of the total in 2021

COVID-19 pandemic

The IPCT has continued proactive work in preventing healthcare outbreaks, supporting clinical areas with outbreak management and support the safe remobilisation of services.

The IPCT annual work plan was reviewed and COVID-19 response prioritised:

- An increase in frequency of IPCT ward/department visits
- Focus on education and training
- Focus on preventing infection in healthcare
- Support to clinical teams to investigate and implement control measures during outbreaks
- Participated in local and national COVID-19 meetings
- Developed a IPC Care Home Team

COVID-19 Care Homes

With increases in demand for IPCT support across NHS Fife due to the COVID-19 response, 2021 also saw a requirement for IPC and Care Home Support, with additional funding granted in December 2020. This allowed a recruitment drive, with trainee IPCNs joining the NHS Fife IPCT in 2021 and a Senior IPCN (secondment). The IPCT supported the new Care Home IPCM and Care Homes Cleaning specification.

The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach. The IPCT have actively promoted the National IPC education and training resources on COVID-19 available on Health Protection Scotland website and the NES modules, which include eLearning- Respiratory protective equipment (RPE), presentations and webinars on COVID-19 and IPC.

Surgical Site Infection (SSI) Surveillance Programme

The CNO suspended the national SSI Surveillance programme in March 2020 in response to the COVID-19 pandemic

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 2021

- **Norovirus**

There has been 2 Norovirus outbreaks.

- **Seasonal Influenza**

There have been no ward closures due to confirmed Influenza outbreaks, however there was a bay closure due to Respiratory Syncytial Virus (RSV).

- **COVID-19**

NHS Fife did experience incidents and clusters of COVID-19, with 37 incidents involving patients and/or healthcare workers reported to ARHAI Scotland. Staff demonstrated great commitment and effort working with the IPCT during outbreaks

Hospital Inspection Team

- The Healthcare Environment Inspectorate inspected Fife once during 2021.
- An unannounced inspection took place at Victoria Hospital, NHS Fife, from 4-6th May 2021.
- This inspection resulted in 7 areas of good practice and 2 IPC requirements.

Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.
- Hand Hygiene audit results of all staff groups by individual ward, hospital or directorate within both the Acute services & HSCP can be viewed on ‘Ward Dashboard’
- NHS Fife overall results remain consistently ABOVE the Overall target set of 95%

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%.

National Cleaning Services Specification and Estates Monitoring

- NHS Fife achieving **Green** status, reported via bi-monthly ICC

Estates – Built Environment

The built environment plays a key role in the prevention and control of HCAI . This also includes pre-meetings and discussions. Systems to Control the Risk of Infection in the Built Environment (SCRIBE) are performed in all healthcare establishments.

Throughout 2021, there continued to be a focus on reducing risk in the healthcare built environment - from the design, construction and adaptation phases of buildings and associated environments, to how they are occupied and maintained by the health care teams using them.

NHS Fife IPCT are currently supporting and providing IPC advice to 2 capital projects:

- NTC Fife Elective Orthopedic Centre
- Lochgelly and Kincardine Health Centers

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.

Quality Improvement Projects for 2021/22 include:

People Who Inject Drugs (PWID) SAB Project
Safe and Clean Care Audit Framework
Urinary catheter improvement Group (UCIG)

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.

Significant focus on IPC Team professional development and recruitment

2.3.3 Financial

With increases in demand for IPCT support across NHS Fife due to the COVID-19 response, also saw a requirement for IPC and Care Home Support, with additional funding granted in December 2020. This has allowed a recruitment drive to commence, with trainee IPCNs joining the NHS Fife IPCT in 2021 and development of a Band 7 Senior IPCN (secondment).

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.

NHS Fife IPCT

Executive Directors Group 20 October 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- NHS Fife Prevention and Control of Infection Annual Report 2020-2021

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

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

NHS Fife

IPCTeam
Infection Prevention & Control

NHS Fife Prevention and Control of Infection Annual Report 2021

Julia Cook Infection Control Manager

Approval Record	Date of Approval
NHS Fife Infection Control Committee	October 2022
NHS Fife Clinical Governance Committee	November 2022
Chief Executive for NHS Fife Board	October 2022

CONTENTS

1.0 INTRODUCTION

Infection Prevention and Control Team (IPCT)

Julia Cook, Infection Control Manager
Craig Webster, Deputy Infection Control Manager (Secondment)
Margaret Selbie, Acting Lead Infection Prevention and Control Nurse (Bank)
Elizabeth Dunstan, Senior Infection Prevention and Control Nurse
Nykoma Hamilton, Infection Prevention and Control Nurse
Janice Barnes, Infection Prevention and Control Nurse
Catherine McCullough, Infection Prevention and Control Nurse
Mirka Barclay, Infection Prevention and Control Nurse
Suzanne Watson, Infection Prevention and Control Nurse
Rosemary Shannon, Infection Prevention and Control Audit Nurse (Bank)
Suzanne Watson, Senior Infection Prevention and Control Nurse (Care Homes)
Sharon Bernard, Infection Prevention and Control Nurse (Care Homes)
Cinzia Jenkins, Infection Prevention and Control Nurse (Care Homes)
Susan Thomson, Infection Prevention and Control Nurse (Care Homes)
Elaine Tate, Infection Prevention and Control Nurse (Care Homes)
Lynsey Delaney, Infection Prevention and Control Surveillance Midwife
Lori Clark, Personal Assistant/Office Manager
Kathleen Diamond, Clerical Officer

Consultant microbiologist	**Number of PAs**	
Dr Keith Morris	4	Provide clinical advice and chair ward outbreaks and incidents within the ASD. Responsible for alter organism surveillance Responsible for SAB, ECB and SSI surveillance and LDP targets
Dr Stephen Wilson	3	Clinical advice, HAI-SCRIBE, Water Safety, Ventilation and Decontamination
Dr Priya Venkatesh	4	IPC advice for HSCP, Oversee CDI surveillance and LDP targets for NHS Fife
Dr David Griffith	1	IPC general duties and AMT
Vacancy	1	General clinical advice
Total	13	

Celebrating Success

During 2021, the Infection Prevention and Control Service have:

- Developed a IPC Care Home Team: Senior Infection Prevention and Control Nurse (secondment) and Infection Prevention and Control Nurses

- Support new IPC team members with post graduate study towards the MSc specialist practitioner qualifications in Infection Prevention and Control.

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

- NHS Fife IPC team have been supporting capital projects such as the National Treatment Centre for Elective Orthopaedic at the Victoria Hospital in Kirkcaldy, Lochgelly and Kincardine Health Centre Project Team

Nationally recognised work

The IPCT supported and continue to support work across a broad range of national stages. The team supported/are supporting:

* **NHS Tayside and the University of Dundee** with a four-year research study; *ARCH: Antibiotic Research in Care Homes*. The aim of the study is to carry out a programme of in-depth multidisciplinary research around how we might safely improve/reduce antibiotic use and ultimately Antimicrobial Resistance (AMR) in care homes. Although there was a temporary pause to this research due to COVID-19 meetings recommenced July 2020 and concluding 2022.

* Participate in the Scottish Antimicrobial Nurses' Group meetings virtually and deputise (as required) representing IPS at the Scottish Antimicrobial Prescribing Group meetings

The team continued to develop the Infection Prevention and Control Service to;

- ✓ focus more on prevention than control
- ✓ sustain and build on achievements and strengths to date
- ✓ ensure that what works is implemented across the healthcare system
- ✓ support greater integration and partnership across the healthcare system
- ✓ ensure we prepare for the future and respond to emerging threats
- ✓ demonstrate our commitment to sustainable improvement
- ✓ promote a culture of zero tolerance of avoidable infections

The Board recognises our collective responsibility towards Healthcare Associated Infection (HCAI) risk and continuously supports our implementation of new initiatives to control these risks. Development, implementation and review of policies alongside surveillance and education are key components of the Infection Prevention and Control Team's proactive approach to addressing the HCAI agenda.

Prevention and control of infection is everyone's responsibility and, as a multidisciplinary team, every member of staff is dedicated to maintaining consistently high standards to ensure patients receive clean, safe care.

2.0 EXECUTIVE SUMMARY

- In response to the World Health Organisation declaration of a COVID-19 pandemic on 11th of March 2020, NHS Fife IPCT focused on supporting the COVID-19 pandemic response through Gold, Silver and Bronze Command structure.

- IPCT continues to work towards improving surveillance, prevention and control of HCAI across Fife through collaborative joint working.

- During 2021, the IPCT workforce challenges including recruitment and retention of staff. The substantive post of Lead Infection Prevention and Control Nurse was unsuccessful in recruitment and the post filled by acting Lead IPCN and Deputy Infection Control Manager (secondment).

- National Hand Hygiene auditing in Fife continues and has shown sustained high levels of compliance.

- Surgical Site Infection (SSI) - pause to national programme.

- Fife continues to comply with national mandatory surveillance requirements.

- The Scottish Government's Chief Nursing Officer in October 2019 announced the new standards for the reduction of Healthcare Associated Infections (Hospital acquired (HAI) & Healthcare associated (HCAI)) for the following: ECB, CDI and SAB.

- *Escherichia coli* bacteraemia (ECB) surveillance continued during 2021. NHS Fife received an exception report for Q3 2021 HCAI ECBs, however NHS Fife witnessed a slight decrease in the number of cases from 2020.

- *Clostridioides difficile* infection (CDI) rates continue at a level below the national average. NHS Fife had a total of 44 CDI cases reported for 2021. This is higher than in 2020, when there were 34 cases, but less than 2019.

- The SAB rate for NHS Fife in 2021 was the lowest year and on target to meet the new reduction standard.

- 2021 saw no outbreaks of influenza.

- NHS Fife did experience incidents and clusters of COVID-19, with 37 incidents involving 2 or more patients and/or healthcare workers reported to ARHAI Scotland. Staff demonstrated great commitment and effort working with the IPCT during outbreaks.

- Due to COVID-19 national restrictions around unnecessary travel, social distancing affected how IPC education and training was delivered, facilitated by an increased investment in IT services and software.

- Fife remains GREEN in the National Cleaning Specification monitoring reports.

- The Healthcare Environment Inspectorate inspected Fife once during 2021. An unannounced inspection took place at Victoria Hospital, NHS Fife, from 4-6th of May 2021. This inspection resulted in 7 areas of good practice and 2 requirements.

NHS Fife has responded to the COVID-19 pandemic, by adopting the best evidence available, responded quickly and effectively to developments and changes in national guidance from the emerging evidence base on COVID-19 which was rapidly evolving. Fife has made significant progress in the prevention and control of infection and the management of SAB, ECB and CDI HCAI during 2021, and responded quickly and effectively to developments and changes in national strategy. This will form a strong base from which to move forward on the challenges of the next twelve months.

Julia Cook, Infection Control Manager on behalf of the Infection Prevention and Control Team

3.0 PURPOSE OF REPORT

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2021-22),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) Standards (2015)* are included.

4.0 INFECTION CONTROL STRUCTURE AND ORGANISATION

4.1 Structures

Infection Control structure is defined within the *Prevention & Control of Infection Implementation Framework 2019-21* which lays down individual responsibilities and committee accountability for delivery of Infection Prevention & Control in NHS Fife and the Health and Social Care Partnership.

In 2021-22, the IPCT reported through the NHS Fife Infection Control Committee (ICC), to the NHS Fife Clinical Governance Committee (NHSF CGC), the HSCP Clinical and Care Governance Committee and the Executive Directors Group (EDG). These groups then reported to the NHS Fife Board and Integrated Joint Board. The ICC meets bi-monthly with minutes of the meeting being widely distributed.

NHS Fife has systems in place to ensure that national requirements for infection control, decontamination and cleaning as laid down in Chief Executive Letters (CEL), Chief Medical Officer for Scotland (CMO) letters, Chief Nursing Officer for Scotland (CNO) letters and other mandatory guidance are identified and addressed. These are disseminated direct to the Infection Control Manager (ICM) from the Scottish Government Health & Social Care Directorate (SGHSCD) Healthcare Associated Infection (HCAI) Policy unit or via the Chief Executive and the Executive Lead for Infection Prevention & Control.

4.2 Staffing and Resources

- The IPCT was successful in recruiting to IPC Care Home Team members; Senior Infection Prevention and Control Nurse and Infection Prevention and Control Nurses. However the IPCT were unsuccessful in recruiting to the substantive post of Lead Infection Prevention and Control Nurse and IPC Surveillance and Auditor.

- Absence was a challenge during the latter half of 2021

- COVID-19 related absences and the requirement for shielding and working from home also impacted the service.

The challenges of COVID-19 have compelled the NHS to make the best use of our people's skills and experience, to provide safe and effective person-centred care. The IPCT has risen to the challenge and has been flexible and adaptable – with new ways of working such as MS Teams meetings training, and safety huddles. Infrastructure to enable

staff to work from home has been facilitated by an increased investment in IT services and software.

With increases in demand for IPCT support across NHS Fife due to the COVID-19 response, 2021 also saw a requirement for IPC and Care Home Support, with additional funding granted in December 2020. This allowed a recruitment drive, with trainee IPCNs joining the NHS Fife IPCT in 2021 and a Senior IPCN (secondment). The IPCT supported the new Care Home IPCM and Care Homes Cleaning specification rollout.

IPCT resource challenges have been highlighted in the HAIRT report and to the ICC and HAI Executive, with assurance there have been interim measures introduced to ensure the safety of the service. This includes seeking supplementary staffing and offering additional hours to existing team members.

5.0 GOVERNANCE

5.1 Internal Audit

The IPCT did not receive any requests for review of IPC services, from the Internal Audit team for this reporting period.

6.0 NATIONAL STRATEGY

6.1 COVID-19 PANDEMIC RESPONSE

A coordinated hospital-wide approach was taken to infection prevention and control including close collaboration with ARHAI Scotland. The IPCT have provided NHS Fife and the HSCP with support and advice for health care workers involved in receiving, assessing and caring for patients who are a possible or confirmed case of COVID-19 in line with national guidance.

The IPC advice in response to the COVID-19 pandemic, is based on the best evidence available from previous pandemic and inter-pandemic periods and the emerging evidence base on COVID-19 which is rapidly evolving. The IPCT have attended national meetings with ARHAI Scotland to be fully informed of the most up to date situation with COVID-19 and current national guidance.

The IPCT annual work plan was reviewed and COVID-19 response prioritised:

- An increase in frequency of IPCT ward/department visits
- Focus on education and training
- Focus on preventing infection in healthcare
- Support to clinical teams to investigate and implement control measures during outbreaks
- Participated in local and national COVID-19 meetings
- Developed a IPC Care Home Team

During the pandemic the IPCT have been working collaboratively with the Health Protection Team, Microbiology, Health and Safety, Occupational Health and Infectious Disease Doctors to support the senior management teams. Local meetings include Hospital Control Teams, Silver Command Procurement, Scientific Technical & Advisory Cell (STAC), Care Home Oversight Group and Care Home Safety Grand Round.

As part of these MDT meetings, IPCT has provided input into the development of patient pathways and the transition to the Winter 2021/22 Respiratory Illness Addendum. Winter planning, outbreak management and supporting the, seasonal influenza vaccination programme and the COVID-19 vaccination programme were a key focus for the IPCT to prepare for the winter season.

Education and training has been provided to all levels of NHS Fife staff and the 74 Care Homes situated across Fife.

6.2 NHS HIS HAI Standards (2015)

The 2015 standards provide the core structure for inspection tools used by the Healthcare Environment Inspectorate (HEI) for hospital inspections.

NHS Fife received one unannounced inspection in 2021

Victoria Hospital Inspection

Unannounced Hospital Inspection to: Victoria Hospital, NHS Fife on 4-6th May 202

The inspection methodology had been adapted to combine safety and cleanliness and care of older people. NHS Boards are measured against a range of standards, best practice statements and other national documents, including the Care of Older People in Hospital Standards (2015) and Healthcare Associated Infection (HAI) standards (2015).

From November 2020 the inspections to acute hospitals will be COVID-19 focused inspections. HIS have adapted their methodology, and we will inspect against existing HAI standards (2015):

- Standard 2 (Education to support the prevention and control of infection)
- Standard 3 (Communication between organisations and with the patient or their representative)
- Standard 6 (Infection prevention and control policies, procedures and guidance), and
- Standard 8 (Decontamination).

The inspection highlighted the following areas of good practice;

- The standard of domestic cleaning was very good.
- Staff wore surgical face masks at all times.
- Staff used PPE correctly and performed hand hygiene at appropriate opportunities.
- Staffing arrangements are right and are responsive and flexible.
- Staff are well supported and confident.
- Staff knowledge and skills improve outcomes for people.
- Nursing staff we spoke with felt they had been supported by the infection prevention and control team throughout the pandemic.
- Staff were kept up to date and were well supported during COVID-19.

The inspection resulted in 2 IPC related requirements;

1. NHS Fife must be assured that patient COVID-19 tests are carried out in line with national guidance and NHS Fife policy, and is documented in the patient's health record.
2. NHS Fife must ensure that the condition of both patient equipment and the environment in the wards in the older part of the building allows for effective decontamination until the wards are relocated as planned.

Action plan has been agreed and submitted.

6.3 HAIRT reporting to Board

As part of the National HCAI Action Plan, all NHS Boards are required to provide a report on HAI during the public session of their bimonthly Board meetings, and to publish this on their website. A national HAI Reporting Template (HAIRT) produced by SGHSCD and revised in June 2010 has been used to update the NHS Fife Board. The report provides a spreadsheet of monthly case numbers and comparative data for ECB, CDI and SABs for individual acute hospitals, for community hospitals and for the community. It also highlights key actions and improvement work aimed at reducing these infections.

7.0 PROGRESS AGAINST INFECTION CONTROL PRIORITIES 2021-22

The Prevention and Control of Infection Work Programme 2021-22 is the NHS Fife delivery plan to comply with the national strategic objectives. The programme of work support the National Quality Strategy ambitions as below.

National Quality Strategy ambitions

Patient centred

Control and prevention of HCAI measures will be proportionate and appropriate for the person receiving healthcare and the environment that healthcare is delivered.

Safe

A clean safe environment and the control and prevention of HCAI and antimicrobial resistance will reduce the risk of the population being exposed to or acquiring an HCAI (including resistant organisms) within any setting, that healthcare is delivered.

Effective

Control and prevention of HCAI measures and programmes, including prudent use of antimicrobial agents, surveillance, new technologies, education, training and research will support effective, equitable and consistent delivery of healthcare.

The *Prevention and Control of Infection Communications Plan 20210- 2023* separately details how the Infection Prevention and Control Team communicate on a formal and informal basis with other colleagues, departments and the public.

Achievements within the seven main delivery areas of the *HAI Task Force Delivery Plan* were reported to the ICC at its bimonthly meetings and to CGC through the ICC minutes and papers. Progress against the seven delivery areas is summarised below.

7.1 Antimicrobial Prescribing and Resistance

7.1.1 Antimicrobial Prescribing Guidelines

NHS Fife has an established antimicrobial management team (AMT) which reports to the NHS Fife Managed Services Drug and Therapeutic Committee. Minutes are provided to the ICC.

The AMT has produced antimicrobial prescribing guidance since 2009 covering adult and paediatric prescribing in both primary and secondary care. Since 2014, the guidance is available as a Smartphone app and via a web viewer. Guidance is reviewed at least every 2 years but with the introduction of the app, it can now be updated instantly and this is done as required.

The aim of guidance is to restrict use of agents particularly associated with *Clostridioides difficile*, to limit the use of very broad-spectrum antimicrobial that may promote emergence of resistant strains, and to ensure that Scottish Antimicrobial Prescribing Group (SAPG) policy on hospital antimicrobial prescribing was met. Guidance takes into account local resistance data collected by the labs.

A protected antimicrobial list covering all wards has been in place since March 2009 and is updated annually or when required.

The antimicrobial pharmacist maintains a database of all AMT guidelines with review dates to ensure they are reviewed every two years (or sooner if necessary), as per the most recent recommendation from SAPG. This activity has been necessarily displaced over the last 18 months by activity related to the COVID-19 pandemic.

7.1.3 Antimicrobial Prescribing Education and Training

Education on antimicrobial prescribing is given at junior doctors' induction to raise awareness and promote use of the guidelines. The AMT has provided training to community prescribers at protected learning time sessions and clinical forum meetings.

In addition to the education given to medical prescribers, IPCT nurses promote the NES AMS workbook for nurses during induction/core update training. Information on the importance of appropriate antimicrobial use is communicated to all staff at NHS Fife Corporate Induction and Statutory Training. The topic is also included in a presentation given to nursing staff at their induction.

A planned focus on promoting timely switch from intravenous to oral antibiotics is currently on hold, pending return a return to more normal NHS and AMT functioning as the COVID-19 pandemic recedes.

7.1.4 Outpatient Parenteral Antimicrobial Therapy (OPAT)

The OPAT service contributes to prevention of healthcare-associated infections (such as MRSA and *Clostridioides difficile*) by allowing earlier discharge or admission avoidance for

patients who would otherwise be confined to hospital solely for the delivery of intravenous antibiotic treatment.

The service also promotes the rational use of antimicrobials, and effective antimicrobial stewardship, through close clinical supervision by infection specialist doctors.

7.2 Cleaning, Decontamination and Estates

7.2.1 Cleaning and Estates Monitoring

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).

The *National Cleaning Services Specification* – quarterly compliance report results for 2021-22 consistently showed NHS Fife achieving GREEN status for both cleaning and for estates monitoring. Results are reported bimonthly to the ICC via the HAIRT report.

7.2.2 Decontamination

The Decontamination Group meets quarterly and receives reports on primary care decontamination in dental Local Decontamination Units (LDU), endoscope decontamination in Endoscope Decontamination Units (EDU), and central decontamination delivered through a Service Level Agreement with Tayside CSSD.

7.2.2.1 Primary Care Decontamination

In NHS Fife, general practice instruments are either single-use or are decontaminated centrally and podiatry services moved to single –use instruments in 2010, so only dental services operate LDUs.

7.2.3 Estates - Equipment Procurement

Nominated IPCNs sit on National Procurement Commodity Advisory Panels (CAPs) and on Board procurement groups as part of NHS Fife's strategy for effective and safe procurement of a wide range of patient related equipment, soft furnishings, furnishings and medical devices.

7.2.3 Estates – Built Environment

The built environment plays a key role in the prevention and control of HCAI . This also includes pre-meetings and discussions. Systems to Control the Risk of Infection in the Built Environment (SCRIBE) are performed in all healthcare establishments. Initially aimed at new builds but include refurbishments and reconfigurations.

- Built environment plays a key role in the prevention and control of HAI
- Gives a holistic approach

- Challenges such as: technical advances, multi-resistant organisms
- Reduce cost in regards to people, work, money and clinical negligence

Throughout 2021, there continued to be a focus on reducing risk in the healthcare built environment - from the design, construction and adaptation phases of buildings and associated environments, to how they are occupied and maintained by the health care teams using them.

NHS Fife IPCT are currently supporting and providing IPC advice to 2 capital projects:

- NTC Fife Elective Orthopedic Centre
- Lochgelly and Kincardine Health Centers

NHS Scotland Assure was formally launched in June 2021 following the request from the Scottish Government for National Services Scotland (NSS) to work with national stakeholders and develop a new national body that aims to reduce risk in the healthcare built environment including risks posed by infectious hazards. An integral workstream of NHS Scotland Assure was the development of the Assurance Service which reviews the design, construction, and maintenance of major infrastructure developments within NHS Scotland at key stages. ARHAI Scotland provided IPC support as subject matter experts in the development of key stage review processes, ensuring an overarching focus on IPC and that infection risk is considered during all stages of the building lifecycle. Supporting materials for each stage in the building lifecycle were developed to support NHSScotland health boards in demonstrating compliance at all the key stages in the build.

7.3 IPC Policy Guidance and Practice

7.3.1 Infection Control Manual

The NHS Scotland National Infection Prevention and Control Manual (NIPCM) first published on 13 January 2012, and was endorsed on 3 April 2017 by the Chief Medical Officer (CMO), Chief Pharmaceutical Officer (CPO), Chief Dental Officer (CDO) and Chief Executive Officer of Scottish Care.

The NIPCM provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS Scotland. In all other care settings to support with health and social care integration the content of this manual is considered best practice.

The NIPCM currently contains guidance on; Standard Infection Control Precautions (SICPs) (Chapter 1), Transmission Based Precautions (TBPs) (Chapter 2) and Healthcare Infection incidents, outbreaks and data exceedance (Chapter 3). In addition to the core chapters, the NIPCM also contains multiple appendices and supporting materials which are constantly being updated as the evidence base evolves. In 2021, a new appendix was added, Appendix 17 which provides information on Aerosol Generating Procedures (AGPs) and post-AGP fallow times.

HPS are currently working towards delivery of comprehensive evidence-based guidance which will form Chapter 4 of the NIPCM on the built environment and decontamination.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

The *NHS Fife Infection Control Manual* is available exclusively in electronic format on the NHS Fife StaffLink powered by Blink and NHS Fife external website.

As per **CNO (2012) 01**, Chapter 1 to 3 of the *National Infection Control Manual* are incorporated into the online NHS Fife manual with direct links. Further sections of the *National Infection Control Manual* will replace NHS Fife chapters as they are published.

Implementation of policy elements is monitored through the Infection Prevention and Control Team audit programme and Senior Charge Nurses fulfil the requirements for SICPs auditing laid down in **CNO (2012) 01** and later modified by the CNO letter of 17 May 12.

Manual sections sit under the overarching Infection Control Policy with the status of Standard Operating procedures (SOPs) which are updated on a rolling programme (every two years in line with HAI Standards 2015).

7.3.2 HCAI Education, Training and Development Strategy: Mandatory and Continuing Education

The *HCAI Education, Training and Development Strategy* was developed to ensure that all staff had access to appropriate HCAI education and training. (Line managers are required to ensure all staff have HCAI objectives in their annual personal development plans).

COVID-19 pandemic has necessitated restrictions upon numbers of staff gathering and on non-essential travel. Therefore restricting ability to provide previous models of education and training. The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach and exploring alternatives to face-to-face training. The IPCT have actively promoted the National IPC education and training resources on COVID-19 available on Health Protection Scotland website and the NES modules, which include eLearning- Respiratory protective equipment (RPE), presentations and webinars on COVID-19 and IPC.

IPCT have collaborated on several training presentations on topics relevant to staff, including outbreaks and terminal cleans. The presentations have been recorded with a voice over, available on StaffLink and can be accessed by all NHS Fife staff.

Throughout 2021, the IPCT have delivered education sessions via Microsoft Teams and small numbers of face to face sessions when risk assessed and deemed essential. These are restricted due to requirement for physical distancing at this time, sessions have include Grand Rounds and training at ward/department level.

HCAI education is a core component of corporate induction, nurse induction, junior doctors' induction, Consultant Mandatory Programme, and Core Update training programmes and

is available as an e-learning module(s) on NHS Fife LearnPro. All NES developed e-learning programmes are available to staff on NHS Fife LearnPro and TURAS Learn.

7.3.3 Hand Hygiene

7.3.3.1 Trends

Publication of National Hand Hygiene Audit data ceased in Sept 2013 with Boards moving to reporting of data in their bimonthly HAIRT reports.

Since then, NHS Fife has maintained a consistently high average compliance. The IPCT carry out Hand Hygiene quality assurance audits as part of the *HCAI Prevention and Control of Infection Assurance Framework*.

7.4 Organisational Structures

7.4.1 Public Involvement

A member of the public is invited to sit on the NHS Fife ICC and contribute to the outcomes of the committee.

7.4.2 Communications

The IPCT has a *Prevention and Control of Infections Communications Plan*, which has been in place since June 2011 (updated accordingly). NHS Fife recognises the importance of having a comprehensive set of accurate, relevant and accessible information available for patients and the public. During the year, NHS Fife Communications Team have played a vital role in providing essential communications to the patients, visitors and population of Fife during the COVID-19 pandemic. Patient and public information leaflets on MRSA, *Clostridioides difficile,* Norovirus, Laundering of Patient Clothing, and Infection Control advice for Patients & Visitors have continued to be provided to wards and clinical areas. Leaflets on peripheral vascular devices, Vancomycin Resistant *Enterococcus* (VRE), Carbapenemase Producing *Enterobacteriaceae* (CPE) and MRSA screening are provided on a targeted basis to patients affected by these issues.

In addition to hard copy leaflets distributed to wards and clinics, these have been made available online to ensure that they are available for staff to use when briefing patients and visitors. Translation services are available on request.

In response to HEI requirements, and to ensure that all patients are provided with relevant HCAI information on admission, the general Infection Prevention and Control advice for Patients & Visitors leaflet is available to all clinical areas for distribution. Banner-stand posters aimed at both staff and visitors reinforce key HCAI messages.

7.5 Staff and Leadership

7.5.1 Structures and accountabilities

In October 2015, the IPCT was reorganised to comply with the *Vale of Leven Public Enquiry Report (2014)* recommendations. The IPC team returned to single system working managed by an Infection Control Manager with responsibility for a Fife wide service.

7.6 Quality Improvement

7.6.1 *Quality Improvement Programmes and partnership working with the Scottish Patient Safety Partnership (SPSP)*

During 2021, the IPCT worked collaboratively to support improvement work in preventing SAB, in supporting improvements in Urinary Catheter Care via the Urinary Catheter Improvement Group (UCIG) and in standardising the Standard Infection Control Precautions (SICPs) audit tool, methodology and reporting via the new Safe and Clean Care Audit Framework.

UCIG update for 2021

To support a reduction in Catheter Associated Urinary Tract Infections & complications and to assist achieving the HCAI *E. coli* bacteraemia (ECB) reduction targets by 2022 & 2024, Fife established a Urinary Catheter Improvement Group (UCIG).

This multi-disciplinary and multi-agency programme works across all of Fife, both in the Acute Services Division (ASD) and the health and social care partnership (HSCP).

The aim of this work is:

- To minimise the incidence of urinary catheters
- To reduce avoidable harm from urosepsis and associated catheter trauma
- To optimise communication of care between all care disciplines & locations
- To optimise education around urinary catheter insertion & maintenance for health care workers, patients & carers
- To optimise documentation of urinary catheter care across Fife
- To improve quality & standardise pathways of urinary catheter care across the system
- To optimise the procurement of catheters & associated devices
- To ensure governance for all urinary catheters to ensure there is robust, accessible, consistently applied and measures (process and outcome) are reported reliably and consistently to provide assurance and data for improvement.

Initiatives up to 2021 include:

- Implementation of the MORSE electronic Urinary Catheter Insertion and Maintenance bundles for District Nursing documentation.
- Urinary catheter insertion and maintenance bundles to be developed and incorporated into Patientrack for Acute services electronic documentation.
- Trial without catheters (TWOC) in the community supported by the use of bladder scanners
- Quality Improvement CAUTI projects within West Fife District Nurse Teams Pathway for complex catheterisation incorporating use of prophylactic antibiotic cover both in an acute and community setting

- Catheter maintenance solutions reviewed to inform standardised guidance for staff
- Implementation of the national catheter passport
- Roll out plan of urinary catheter valves & Tiemann tip catheters
- Promotion of hydration and optimisation of continence care, by continence services, to all care homes/residential homes in Fife
- All CAUTI ECBs associated with trauma during insertion or removal/self removal, submitted for DATIX to maximise learnings
- Monthly reporting and graphs to support data for governance provided.

Safe and Clean Care Audit Framework

This programme of work was established to standardise the current SICPs audit tool and provide a consistent and reliable method for IPC auditing in NHS Fife. The tool is built on the *National Monitoring Framework to Support Safe and Clean Care Audit Programmes: An Organisational Approach to Prevention of Infection Auditing (2018).*

The *National Monitoring Framework for Safe and Clean Care Audits* has been produced as an agreed recommended minimum approach to auditing for all NHS boards. The framework applies to all audits of prevention of infection practice across primary and secondary care settings. The framework supports a strategic approach to *Safe and Clean Care Audis* in line with the *HIS HAI Standards (2015).*

NHS Fife was the first board in Scotland to develop a tool based on the national framework, which went live September 2019. To help achieve a consistent approach to auditing, there is currently over 400 trained auditors, who have electronic access to the tool. 2021 saw a focus on increasing uptake across NHS Fife with the IPCT supporting clinical teams with their role out of the tool.

People Who Inject Drugs (PWID) SAB Project update for 2021

A reduction in total number of SAB infections were identified in people who inject drugs (PWID) was noted in 2021 with 4 cases, this is down from 5 cases in 2020 and 13 cases identified in 2019. IPC aim for 2021 was to focus on training Nurse Prescribers within Addiction Services to support timely treatment of skin and soft tissue infections with an aim to continue to reduce SABs and improve Addictions service users safety. However the COVID-19 pandemic restrictions have impacted Addictions Services, with a greatly reduced footfall through clinics and a delay in the project.

7.7 Surveillance

7.7.1 Surgical Site Infection (SSI)

A CNO letter on 25 March 2020 advised of changes to HAI surveillance requirements with temporary changes to routine surveillance:

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

7.7.1.1 Caesarean section

Due to the COVID-19 pandemic, there has been a temporary pause on SSI surveillance, until further notice from Scottish Government. Maternity Services have continued to monitor their Caesarean Section SSI cases liaising with the IPCT and incidence of infections reported via Fife Integrated Performance and Quality Report. Note that the performance data provided is non-validated and does not follow the agreed NHS Fife Methodology, and that no national comparison data has been published since Quarter 4 2019.

Table 1: Caesarean section SSI incidence for inpatients and post discharge surveillance (day 10)

	2021			
Quarter	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
NHS Fife	2.70%	3.60%	2.50%	1.60%

Table 1 - from the local surveillance of Caesarean section SSI, throughout all of 2021, NHS Fife consistently achieved infection incidence rates below the reduction target for the later half of 2021. Aim for 2022 to continue to sustain this improvement.

The SSI Implementation Group continued to meet, until the group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there is a robust system in place for reviewing any Deep or Organ Space SSI cases via a local adverse events review (LAER). The group will re-establish should any future concerns develop.

7.7.1.2. Hip Arthroplasty

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.3. Large Bowel

All Large Bowel surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.4.a **Standards on Reduction of Healthcare Associated Infections**:

The New standards have been announced by the Scottish Government's Chief Nursing Officer in October 2019 for the reduction of Healthcare Associated Infections (Hospital acquired (HAI) & Healthcare associated (HCAI)) for the following:

For *E. coli* bacteraemia (ECB)

- New LDP standards are to reduce incidence of healthcare associated ECB by **25%** from 2019 to 2022, utilising 2018/19 as baseline data
- And a 2nd reduction standard of **50%** by 2023/24 (from 2018/19 baseline):

Table 2: **25% reduction ECBs - 2021/2022**

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 TBDs	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**

Table 3: **50% Reduction ECBs - 2023/2024**

1) 50% Reduction ECBs - 2023/2024		
New standards for reducing all Healthcare Associated ECB by 50% by 2023/2024 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 50% reduction target by 2023/4**
ECB by rate 100,000 TBDs	**44.0** per 100,000 TBDs	**22.0** 100,000 TBDs
ECB by Number of HCAI cases	**160**	**80**

For *Clostridioides difficile* infection (CDI)

- New LDP standards are to reduce incidence of healthcare associated CDI by **10%** from 2019 to 2022, utilising 2018/19 as baseline data:
-

Table 4: **New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline)**

New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline)		
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2022**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**

For *Staphylococcus aureus* bacteraemia (SABs)

- New LDP standards are to reduce incidence of healthcare associated SAB by **10%** from 2019 to 2022, utilising 2018/19 as baseline data:
  Table 5: **New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline)**

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline)		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2022**
SAB by rate 100,000 Total BDs	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**

7.7.2 Escherichia coli Bacteraemia (ECB)

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli,* and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals, care homes, under social care and the wider community.

Nationally during 20201, there were 4,292 cases of ECB in Scotland with a rate of 78.5 per 100,000 population. There has been a 3.4% year-on-year decrease over the last 5 years, however the rate remained stable between 2020 to 2021. Healthcare associated ECB saw a 6.4% decrease in the rate between 2020 and 2021. Whereas for community associated the rate remained stable between 2020 and 2021.

Locally during the surveillance period of 2021 there was a total of 249 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

The ECB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the second year of the pandemic and the two lockdown which occurred surgical procedures were carried out but the service was limited. This may have influenced the number of hospital acquired ECB.

COMMENTS

- The total number of ECB remains static over the last six years. However the number of infections in men appears to be increasing while infections in women are decreasing
- The age range for an *E.coli* bloodstream infections is skewed towards the over 50s with the peak of infections occurring in the age range 80-89 years of age. This possibly reflects the age of patients with most co-morbidities.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by urethral catheters. However in hospital acquired ECB, urethral catheters are the second most common source of infection.
- Hospital patients only account for ~20% of the total ECB therefore reducing ECB to achieve the LDP will require infection prevention measures in both the hospital sector and in the Health and Social Care Partnerships.
  (See Appendix 1: ECB Annual report for full details)

Quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infection in patients; to prevent these infections developing into bloodstream infections.

7.7.3. *Clostridioides difficile Infection* (CDI)

Clostridioides difficile is a bacterium found in people's intestines. Healthy people may have in gut flora, where it causes no symptoms. However, it may cause disease when the normal bacteria in the gut are disadvantaged, usually by antibiotics. When *C. difficile* is able to multiply this allows its toxins to reach levels where it attacks the intestines and

causes mild to severe diarrhoea. *C. difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel.

Nationally during 2021, 1,135 cases of CDI in patients aged 15 years and older were reported in Scotland. While there has been a 5.8% year-on-year decrease over the last 5 years, the rate has remained stable between 2020 and 2021. This decrease has been evidenced in community associated CDI rather than Healthcare associate in which the rate has remained stable over the last 5 years.

Locally, NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 5 years. Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

RESULTS

Between 1st January and 31st December 2021 there were a total of 44 cumulative episodes of CDI in patients aged ≥ 15 years in Fife.

There were 16 hospital associated infection (HAI) CDI, 9 healthcare associated infections (HCAI) and 3 unknowns. Further to this, 16 CDI infections were community associated infections (CAI).

Of the 44 cases there were 5 episodes of recurrent CDI, this is the lowest number of recurrent infections since 2016 (Appendix 2: CDI Annual Report 2021).

COMMENTS

1. Compared to 2020 there has been a 29% increase in the total number of CDI. (NHS Fife achieved the lowest annual total on record for 2020).
2. In 2021 there were 5 recurrences of CDI

Management of recurrence of CDI for 2021 & for 2022

Recurrent CDI remains an ongoing challenge in NHS Fife.

Patients with recurrent CDI are advised pulsed Fidaxomicin and are followed up until day 30.The use of extended pulsed Fidaxomicin (EPFX) to address recurrences have shown a good outcome.

Bezlotoxumab has been used in cases where other modalities have failed. This continues to be in place as commercial faecal transplant is still unavailable and NHS Fife who do not have provision for this locally.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2022

Continue stewardship advice where any inappropriate prescribing is identified.

General advice against using of quinolones wherever possible is given to both GPs and hospital doctors as part of routine antibiotic advice.

Key actions for 2022

Continued surveillance and follow up all CDI cases.

NHS Fife will continue to use the EPFX regime for the high risk groups to prevent recurrence.

7.7.4 *Staphylococcus aureus Bacteraemia (SAB)*

Staphylococcus aureus is a bacterium that commonly exists on human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. If the bacteria enter the body, illnesses, which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves, pneumonia and blood stream infection (bacteraemia).

Nationally during 2021, 1,590 cases of SAB were reported in Scotland, with 3.6% reported as meticillin resistant S. aureus (MRSA) bacteraemias and 96.4% as meticillin sensitive S. aureus (MSSA) bacteraemias. For both MSSA and MRSA the rate has remained stable between 2020 and 2021. There was a decreasing year-on-year trend for MRSA over the last 5 years, however the incidence rate of MSSA has remained stable over this time period.

Locally the SAB epidemiology in this report occurred during the second year of the SARS-CoV-2 pandemic and must be considered in this environment. During the second year of the pandemic the Health Board has tried to maintain elective surgical program, but the pandemic has influenced the number of hospital admissions. There have been three post COVID-19 SAB. In two the entry point was a *S. aureus* ventilator associated pneumonia. There was one post COVID *S. aureus* pneumonia where mechanical ventilation was not in use.

RESULTS

Locally during 2021 in NHS Fife there was a total of 80 SAB. 73 SAB were identified in the Victoria Hospital and four were acquired in Queen Margaret Hospital. Two patients had their *S. aureus* bloodstream infection identified in other HSCP hospitals. One patient under the care of Hospital at Home acquired a *S. aureus* bacteraemia. MSSA accounted for 78 cases (97.5%) and 2 cases (2.5%) were due to MRSA (see Appendix 3: Annual SAB Report for full details).

COMMENTS

1. Compared to 2020 there has been a 2.4% decrease in the number of SAB. This is the lowest annual total on record.
2. In 2021 there were two MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
3. The proportion of hospital acquired SAB in 2021 was 37.5%
4. The proportion of VADs resulting in a hospital acquired SAB in 2021 was 30%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. Two SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug remained stable at 5 episodes in 2021.
7. To reduce SAB further focus on; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.
8. SAB where the entry point is not known remain a significant problem and accounted for 23.75% percent of the total in 2021

- ***7.7.5 National MRSA and CPE screening programme***

The MRSA Screening Key Performance Indicator (KPI) for 2021-2022 remains set as '*90% of all acute admissions must have CRA within 24 hrs of admission'.*

Table 6: MRSA CRA Compliance to end 2021

MRSA				
MRSA Critical risk assessment (CRA) screening KPI compliance summary:				
Quarter	**Q1 2021 Jan-Mar**	**Q2 2021 April- June**	**Q3 2021 Jul-Sept**	**Q4 2021 Oct-Dec**
Fife	95%	98%	88%	93%
Scotland	83%	84%	81%	82%

Table 7: CPE CRA Compliance to end 2020

CPE (*Carbapenemase Producing Enterobacteriaceae*)				
For 2021, CRA has also included screening for CPE				
Quarter	**Q1 2021 Jan-Mar**	**Q2 2021 April- June**	**Q3 2021 Jul-Sept**	**Q4 2021 Oct-Dec**
Fife	88%%	90%	100%	**98%**
Scotland	82%	83%	82%	80%

Compliance with MRSA CRA completion fluctuates however is predominantly above the Scottish national average and within the 90% compliance target in 2021 (Table 6). Compliance with CPE CRA has improved since Quarter 1 2021 (Table 7). With the IPC worked closely with Excellence in Care and Digital Information, developed a national tool for Multi-Drug Resistant Organisms surveillance, which is be used locally. This tool support a consistent pathway for the clinical risk assessment of patients and patient placement.

7.7.7 Outbreaks and Incidents

7.7.7.1 Norovirus

The year of 2021 saw 2 outbreaks of Norovirus

7.7.7.2 Other Outbreaks

For the year of 2021 there were NO wards/bays closed due to Influenza, however there was a bay closure due to Respiratory Syncytial Virus (RSV).

7.7.7.3 COVID-19 Clusters and Incidents related to healthcare

The IPCT provided support to clinical teams to investigate and implement control measures during the COVID-19 pandemic which saw a significant increase in incidence of COVID-19 respiratory illness. There were 37 incidents/clusters that involved patients and/or healthcare workers.

7.7.8 Infection Control Audits

The IPC audit programme provides assurance to the organisation that the required HAI standards are being met board wide. The focus is on intelligence led auditing which will assist in validating the ward level audit programme and ensure a consistent approach is taken.

A two-year rolling programme was initially commenced in August 2016 and again in 2018; which encompasses all divisions and a wide range of clinical areas.

Due to the COVID-19 pandemic response there was 2 pauses to the programme of audit during 2020. As part of the remobilisation of services, the audit programme was recommenced in July 2020 with the appointment of a part time IPC Audit Nurse.

The IPC nurses prioritise areas where issues with compliance have been identified through either observation or other assurance processes provided by other services within the board.

Monitoring and reporting of Estates issues is conducted by the domestic teams as part of NHS Scotland National Cleaning Standards monitoring and Quality Assurance team undertake additional audits.

Auditing of Standard Infection Control Precautions is the responsibility of Senior Charge Nurses (SCNs) as part of the Leading Better Care Programme (LBC). In addition to this, the IPC launched the new *Safe and Clean Care Audit* framework in September 2019 with mixed initial uptake. A renewed focus on the programme is currently underway with support from senior leaders across NHS Fife.

7.7.9 2021 Surveillance Summary:

- Surgical Site Infection (SSI) rates pause to national programme

- Rates for Caesarean Section achieved local incidence targets, however there are no National comparators due to cessation of the Mandatory National SSI programme

- *Escherichia coli* bacteraemia (ECB), NHS Fife witnessed a slight decrease in the total number of cases in 2021 compared to 2020. Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTIs) remain the prevalent source of ECBs and are therefore the two areas to address to reduce the ECB rate

- *Clostridioides difficile* infection (CDI) rates continue at a low level, achieving rates below the national average: for HCAI Infection Rate and community associated infection rates. Pioneering work to reduce incidence of recurrent infection introduced in 2019 has continued.

- The total number of SAB rate for NHS Fife in 2021, was the lowest year with 80 cases reported. There were 2 MRSA bacteraemias identified in 2021, the fifth consecutive year where the proportion of invasive MRSA has been less than 5%.

- 2021 did not see influenza outbreaks.

- COVID-19 incidents and clusters – 37 reported to ARHAI Scotland, wards and staff demonstrated great commitment and effort working well with IPCT during the COVID-19 pandemic.

8. REFERENCES

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www.sehd.scot.nhs.uk/mels/CEL2008_20.pdf

SGHD HAI Taskforce Delivery Plan 2011 and beyond (2011)
http://www.scotland.gov.uk/Resource/0039/00398323.pdf

SGHD HAI Action Plan (2008)
www.scotland.gov.uk/Resource/Doc/924/0064225.pdf

Healthcare Associated Infection (HAI) standards (2015)
www.healthcareimprovementscotland.org/his/idoc.ashx?docid=90f299a8-d500-4285-9eeb-f6f9b05457db&version=-1

HPS HAI Annual Report 2018

HFS National Cleaning Services Specification: Quarterly Compliance Reports
www.hfs.scot.nhs.uk/online-services/publications/hai/

Scottish Management of Antimicrobial Resistance Action Plan 2 (ScotMARAP) (2014)
https://www.scottishmedicines.org.uk/SAPG/News/ScotMARAP2_final.pdf

Vale of Leven Hospital Enquiry Report: November 2014

COVID-19

Date	Issued CNO Letters
09/12/2020	Guidance on expansion of twice weekly testing for patient facing staff within hospitals, the Scottish Ambulance Service and COVID-19 Assessment Centres – Latest guidance on staff testing can be accessed here
27/11/2020	Letter on the Testing Expansion Plan – Staged Roll-out – Summary table providing an overview of all hospital testing requirements here (updated on ongoing basis); Testing section of COVID Addendum here; and Chief Executive letter on Testing Expansion Plan here
27/10/2020	The Scottish COVID-19 Infection Prevention and Control (IPC) Addendum for acute healthcare settings - Accessed here
19/10/2020	Letter reiterating existing IPC policies and guidance in light of increasing transmission – Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here
16/10/2020	Letter on serial testing of patients determined by local epidemiology – Summary table providing an overview of all hospital testing requirements here (updated on ongoing basis); Testing section of COVID Addendum here; and Chief Executive letter on Testing Expansion Plan here
22/09/2020	Letter re guidance for physical distancing requirements in NHS Scotland For ease of reference: Built environment physical distancing guidance and signage is publicly available at: NHSS Social Distancing Guidance & Signage (nhsnss.org).
18/09/2020	Letter re revised guidance on the extended use of facemask guidance and face coverings in hospitals, primary care, wider community care and adult care homes. Guidance found here

14/08/2020	Letter on publication on UK IPC guidance for the remobilisation of health and care services - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
03/07/2020	Letter and guidance on asymptomatic staff testing in high-risk specialties. Latest guidance of staff testing can be accessed here
01/07/2020	Letter re assurance - COVID-19 Remobilisation plans to reduce the risk of nosocomial COVID-19 - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
29/06/2020	Letter on COVID-19 Remobilisation plans to reduce the risk of nosocomial COVID-19 - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
23/06/2020	Letter re interim guidance on the wider use of facemasks and face coverings in health and social care. Guidance found here
26/05/2020	Letter on guidance on the reuse of PPE - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
02/04/2020	Letter on publication of revised COVID-19 UK IPC guidance - Scottish COVID Addendum for acute settings - latest guidance on IPC consolidated here and UK Guidance for the remobilisation of services within health and care settings
25/03/2020	Letter to NHS Scotland Boards regarding revised HAI surveillance requirements

Update to Scottish NIPCM Covid 19 IPC Addendum for Acute Settings

Date	Issued CNO Letters
20/11/2020	New Section on communications when transferring a suspected/confirmed case New Section on car sharing New section on visiting
09/11/2020	New Section on Personal Protective Equipment (PPE) requirements of delivery of vaccinations New Section on outbreaks
18/12/2020	New Section on covid-19 testing New section on patients returning from weekend/day pass. New section on WGS Link added to Royal college of Paediatrics and Child Health (RCPCH) paediatric guidance for pre-operative admission assessment and testing requirements. New Fluid Resistant Surgical Masks (FRSM) poster (ways to improve fit)
22/01/2021	New section on guidance for the discontinuation of infection control precautions and discharging COVID-19 patients from hospitals New section on hierarchy of controls Update to PPE guidance specifically in relation to visitors Update to the COVID 19 testing section and associated testing table.
18/02/2021	Additional wording added to definition of suspected case section to reflect wide variety of presenting symptoms Strengthening of triage question relating to travel history

	Additional paragraph in PPE section reinforcing need for visiting staff to seek clarity on patient pathway and PPE requirements prior to a patient contact.
26/03/2021	Update to stepdown requirement for inpatients to recognise need for clinical assessment. Sessional PPE use no longer accepted beyond eye protection in the high risk pathway Useful tools section added
07/05/2021	Inclusion of reference to undertaking risk assessments in clinical areas and using the hierarchy of controls Requirement for respiratory protective equipment (RPE) if unacceptable risk of transmission remains
15/05/2021	Change to AGP list to remove upper airway suctioning during upper gastrointestinal (GI) endoscopy and replace with suctioning beyond the oro-pharynx (change agreed by the UK IPC Cell)
18/05/2021	Update to COVID-10 testing table to reflect the need to test all the contacts of confirmed cases
25/06/2021	Update to PPE table to emphasise risk assessment in low and medium risk pathway Addition of risk associated with valved respirators (not to be used when sterility required over a surgical field/site)
05/07/2021	Admission of individuals to the care home: section has been updated with changes to testing and self-isolation in certain circumstances Patients discharged from hospital to care homes (non COVID 19)- wording added to provide advice for self-isolation requirements upon admission to care home
19/07/2021	Inclusion of specific paragraph advising the use of FFP3 masks Update to hierarchy of control including risk assessment algorithm.
31/08/2021	Update to physical distancing – situations for reduction to 1 metre
29/11/2120	COVID-19 Addenda superceded by the new Scottish Winter (21/22) Respiratory Infections IPC addendum

Appendix 1: 2021 Annual ECB Report

Annual report: *E. coli* bacteraemias (ECB) in NHS Fife from 1st January 2021 to 31st December 2021
Dr Keith Morris, Microbiologist & Infection Control Doctor

INTRODUCTION
The report demonstrates the *E. coli* bacteraemia (ECB) epidemiology in 2021. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *E. coli* bacteraemia.

Data for this report has been obtained from surveillance carried out by consultant microbiologists and the Infection Control Surveillance Audit Nurses in NHS Fife. During the surveillance period there was a total of 249 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

The ECB epidemiology in this report occurred during the SARS-CoV-2 pandemic and must be considered in this environment. During the second year of the pandemic and the two lockdown which occurred surgical procedures were carried out but the service was limited. This may have influenced the number of hospital acquired ECB.

RESULTS

Between 1st January and 31st December 2021 there were 249 episodes of ECB. 145 occurred in males and 104 in females Figure 1 demonstrates the trend in the number of ECB over the last six years split by gender.

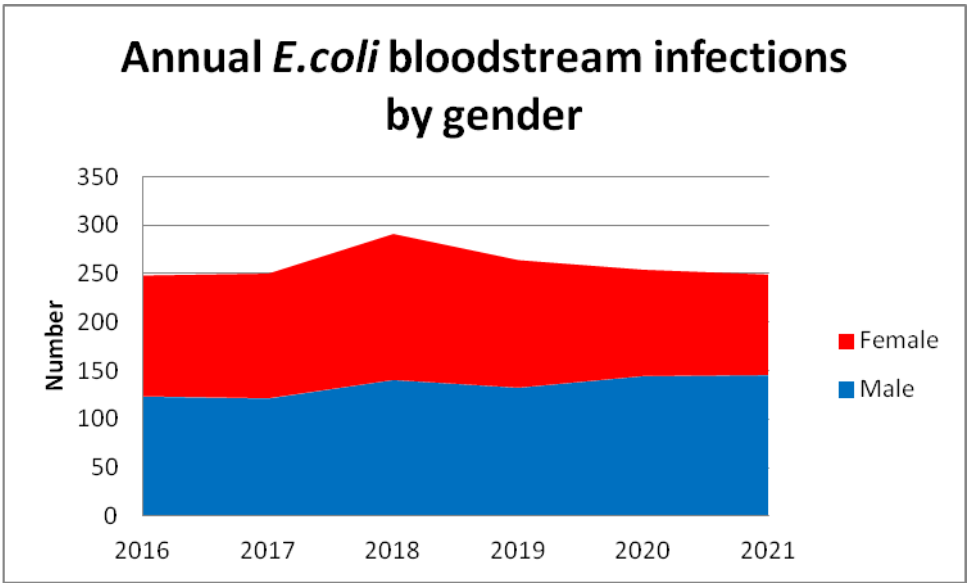


Figure 1: Trend in ECB by gender

Appendix 1 demonstrates that gender does have a role to play in the entry points for ECB. Males are more likely to have a urethral catheter as the cause of an ECB, while lower UTI as an entry point is more common in women.

Figure 2 demonstrates that the number of ECB increases with age.

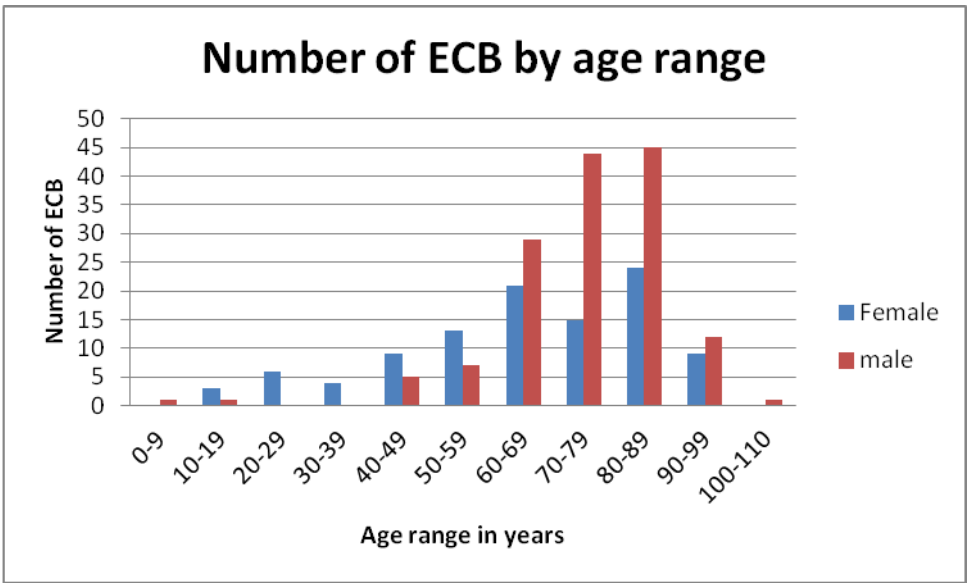


Figure 2 number of ECB by decade of life

52 (20.8%) of ECB episodes were hospital acquired and 197 (79.1%) were non hospital acquired. Non hospital ECB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections.

Figure 3 demonstrates the trend between hospital acquired and non-hospital ECB over the last five years.

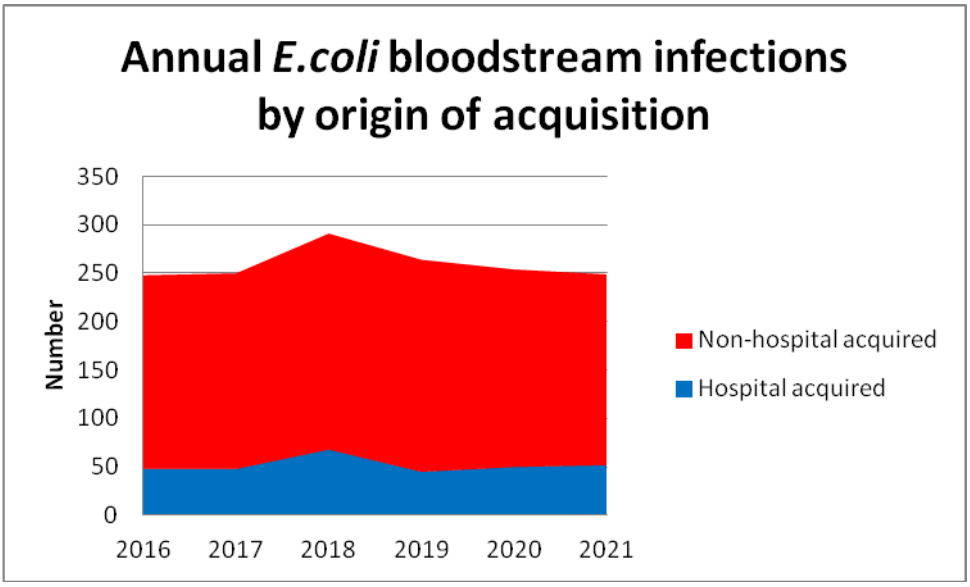


Figure 3: Annual ECB by origin of acquisition

Figure 4 presents data on the entry point of each hospital acquired ECB by system during 2021.

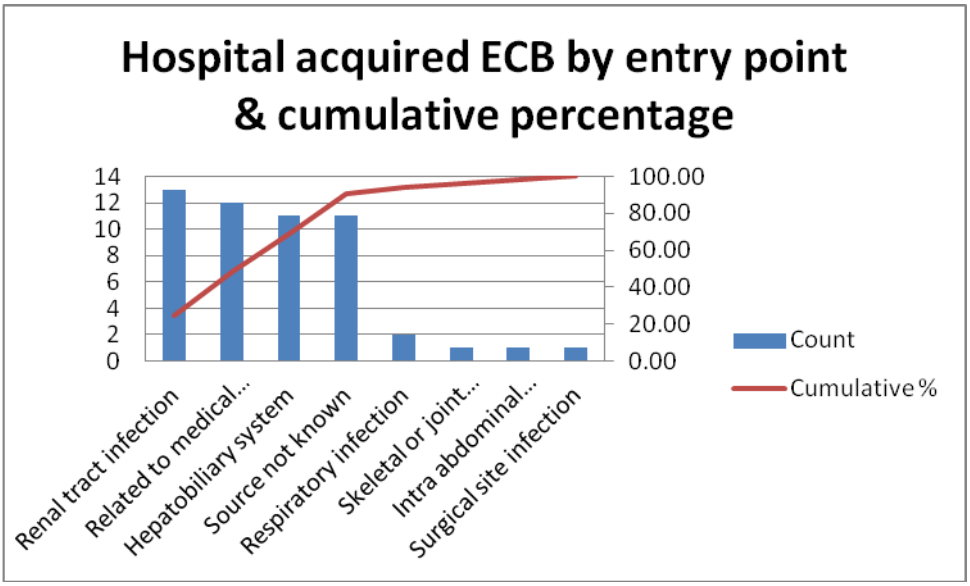


Figure 4: Pareto chart demonstrating the entry point by system of each hospital acquired ECB. More detail on the source of each ECB can be found in appendix 1.

10 of the “Renal tract infections” were due to lower UTI, Three were due to infections of the upper urinary tract.
Nine of the Medical device infection were due to catheter associated UTI (CAUTI) and three were due to ventilator associated pneumonias.

Figure 5 presents data on the entry point of each non hospital acquired ECB episode during 2021.

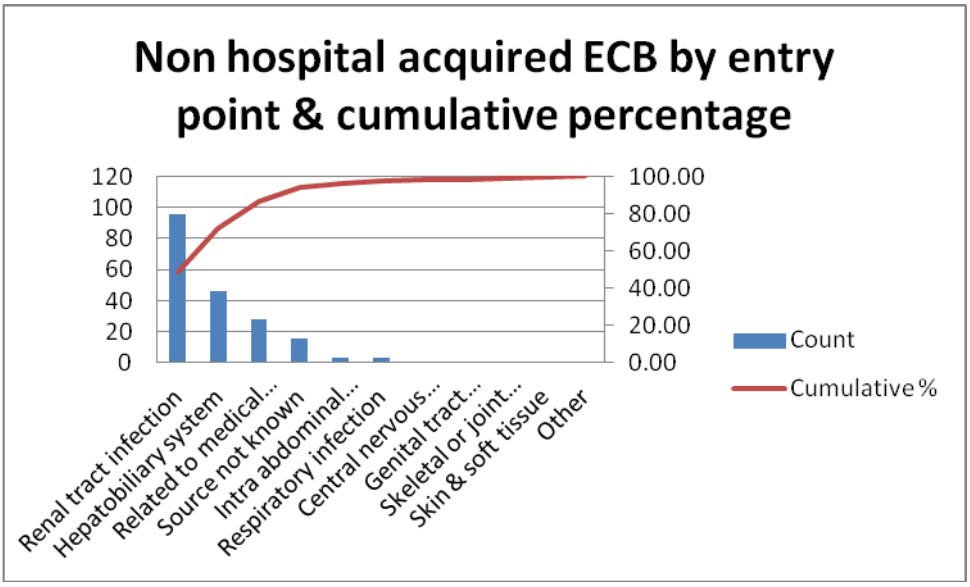


Figure 5: Pareto chart demonstrating the entry point by system of each non hospital acquired SAB.

55 of the renal tract infections acquired outside hospital were due to lower UTI and 41 were related to the upper urinary tract. There were 28 medical device related infections. 25 were due to urethral catheters and one was due to a supra-pubic catheter. The other two device related infections were due to a nephrostomy and an oesophageal stent.

COMMENTS

- The total number of ECB remains static over the last six years. However the number of infections in men appears to be increasing while infections in women are decreasing
- The age range for an *E.coli* bloodstream infections is skewed towards the over 50s with the peak of infections occurring in the age range 80-89 years of age. This possibly reflects the age of patients with most co-morbidities.
- In both hospital acquired infections and non-hospital acquired infections the renal tract is the major source of infection with lower UTI the major entry point.
- In non-hospital acquired infections hepato-biliary infections are the second most common cause of an ECB followed by urethral catheters. However in hospital acquired ECB, urethral catheters are the second most common source of infection.
- Hospital patients only account for ~20% of the total ECB therefore reducing ECB to achieve the LDP will require infection prevention measures in both the hospital sector and in the Health and Social Care Partnerships.

Quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infection in patients; to prevent these infections developing into bloodstream infections.

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). The letter set out a reduction of 50% in healthcare associated E. coli bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22. 2018/19 should be used as the baseline for E. coli bacteraemia reduction.

In the letter healthcare associated ECB includes hospital acquired infections plus healthcare associated infection as described in the table in appendix 2.

Appendix 1
System involved split by gender

System	Female	Male	Grand Total
Central nervous system infection		1	1
Genital tract infection including prostate in males and the reproductive organs in females		1	1
Hepatobiliary system	23	34	57
Intra abdominal infection (other than HB)	1	3	4
Other: please specify	1		1
Related to medical device other than VAD	9	31	40
Renal tract infection	59	50	109
Respiratory infection	2	3	5
Skeletal or joint infection	1	1	2
Skin & soft tissue		1	1
Source not known	8	19	27
Surgical site infection		1	1
Grand Total	**104**	**145**	**249**

Appendix 2

Entry point for each ECB episode by origin

System involved	Community infection (*n=124*)	%	Healthcare Associated Infection (HCAI) (*n=73*)	%	Hospital Acquired infection (HAI) (*n=52*)	%	Total (*n=249*)	%
Central nervous system infection	1	0.81				0.00	1	0.40
Genital tract infection including prostate in males and the reproductive organs in females	1	0.81				0.00	1	0.40
Hepatobiliary system	31	25.00	15	20.55	11	21.15	57	22.89
Intra abdominal infection (other than HB)	2	1.61	1	1.37	1	1.92	4	1.61
Other: please specify			1	1.37		0.00	1	0.40
Related to medical device other than VAD	1	0.81	27	36.99	12	23.08	40	16.06
Renal tract infection	75	60.48	21	28.77	13	25.00	109	43.78
Respiratory infection	2	1.61	1	1.37	2	3.85	5	2.01
Skeletal or joint infection	1	0.81			1	1.92	2	0.80
Skin & soft tissue	1	0.81				0.00	1	0.40
Source not known	9	7.26	7	9.59	11	21.15	27	10.84
Surgical site infection					1	1.92	1	0.40
Total	**124**		**73**		**52**		**249**	

*The numbers in red highlight the three most common ECB by system

Appendix 2: 2021 Annual CDI Report -

Annual report: *Clostridioides difficile* infection (CDI) in NHS Fife from 1st January 2021 to 31st December 2021

INTRODUCTION

The report demonstrates the *Clostridioides difficile* infection **(**CDI) epidemiology in 2021. The Infection Control Committee is asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of CDI.

Data for this report has been obtained from surveillance carried out by the IPCT Surveillance and Audit Midwife and Dr Venkatesh. During the surveillance period there was a cumulative total of 44 CDI.

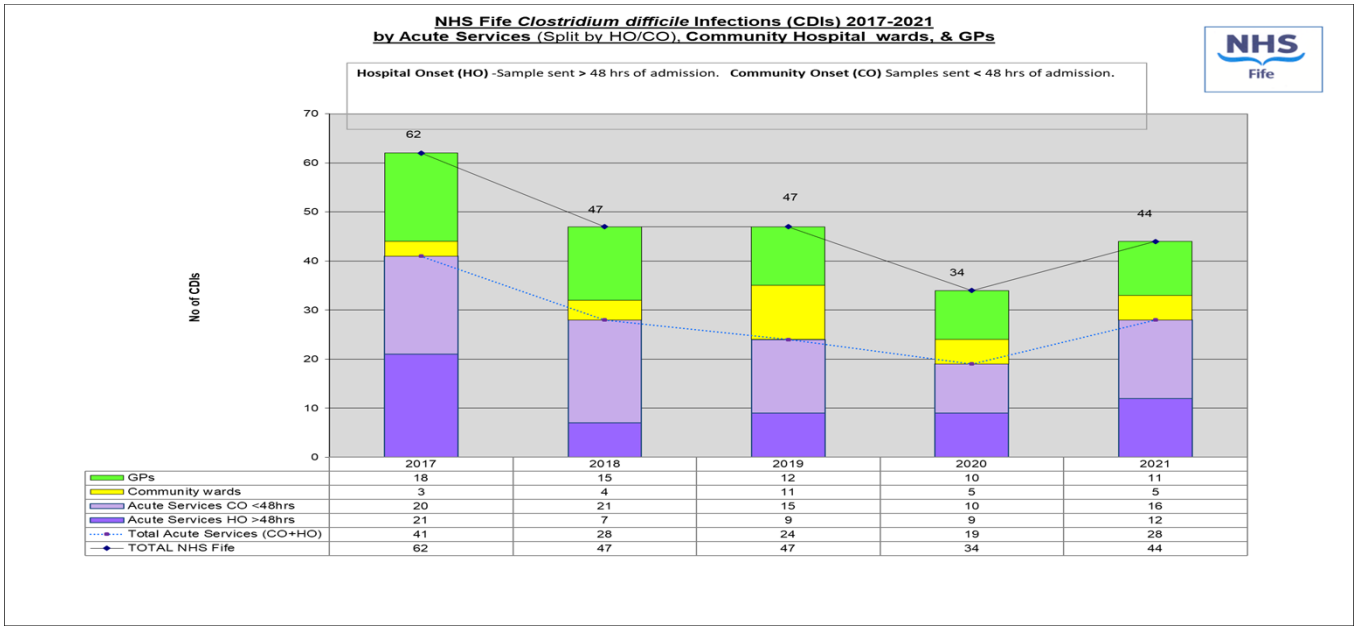
The CDI epidemiology in this report occurred during the second year of the SARS-CoV-2 pandemic and must be considered in this environment. During the second year of the pandemic the Health Board has tried to maintain elective surgical program, but the pandemic has influenced the number of hospital admissions.

NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 5 years (see Figure 1). Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

Each improvement strategy has contributed to the overall reduction since 2017:-

- 29% overall reduction in total number of cases
- 32% reduction in the Acute Services Division (ASD)
- 24% reduction in community wards and GP surgeries

Figure 1: CDI 2017 to 2021



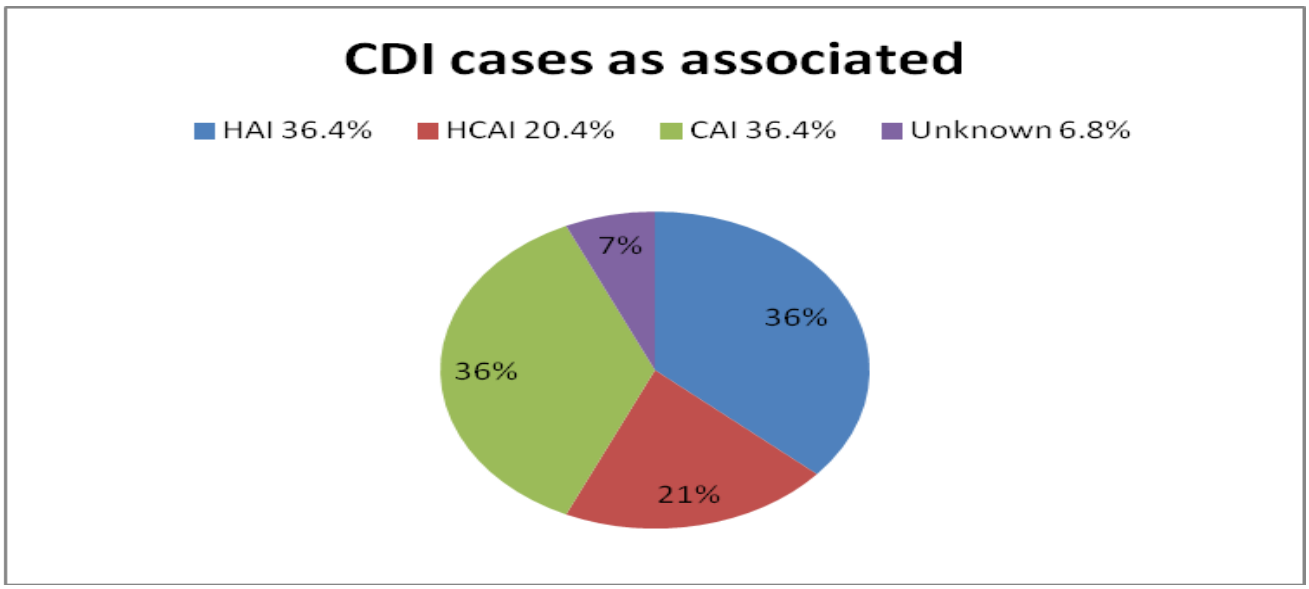
	2017	2018	2019	2020	2021
GPs	18	15	12	10	11
Community wards	3	4	11	5	5
Acute Services CO <48hrs	20	21	15	10	16
Acute Services HO >48hrs	21	7	9	9	12
Total Acute Services (CO+HO)	41	28	24	19	28
TOTAL NHS Fife	62	47	47	34	44

RESULTS

Between 1st January and 31st December 2021 there were 44 episodes of CDI in patients aged ≥ 15 years in Fife.

There were 16 hospital associated infection (HAI) CDI, 9 healthcare associated infections (HCAI) and 3 unknowns. Further to this, 16 CDI infections were community associated infections (CAI) (see Figure 2).

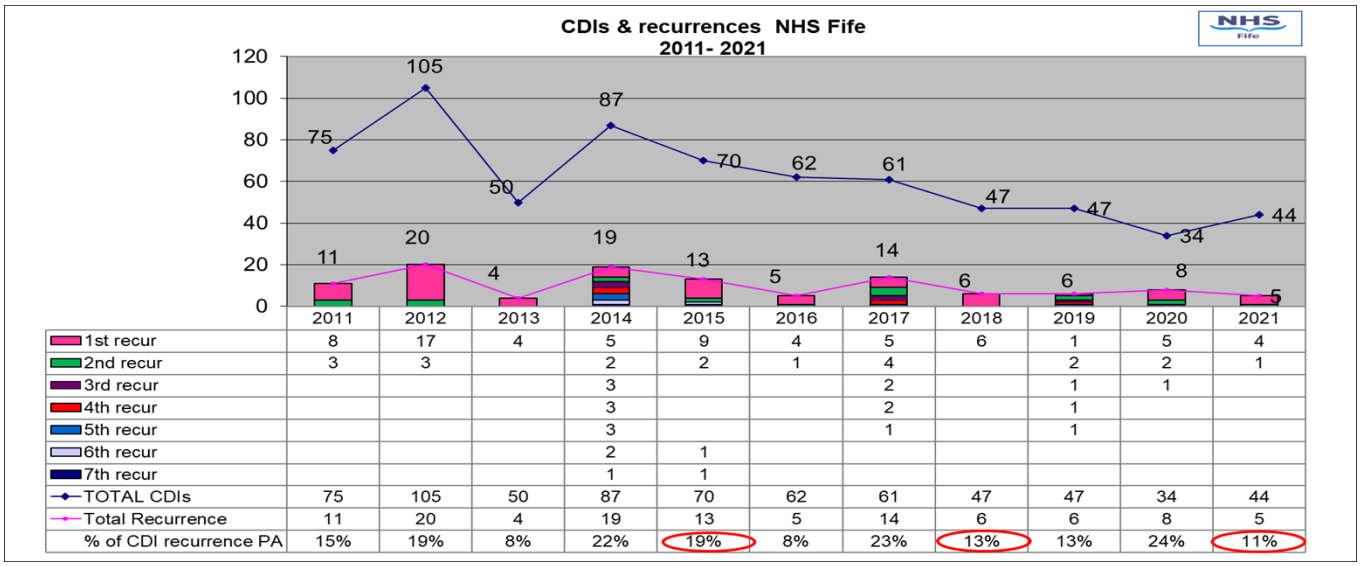
Figure 2: CDI cases as associated



Of the 16 HAI, 12 were associated to the Victoria Hospital and 2 were acquired in Queen Margaret Hospital. One CDI identified in St Andrews Hospital and another in Cameron hospital.

Of the 44 cases there were 5 episodes of recurrent CDI, this is the lowest number of recurrent infections since 2016 (see Figure 3).

Figure 3: CDI recurrences 2011-2021



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1st recur	8	17	4	5	9	4	5	6	1	5	4
2nd recur	3	3		2	2	1	4		2	2	1
3rd recur				3			2		1	1	
4th recur				3			2		1		
5th recur				3			1		1		
6th recur				2	1						
7th recur				1	1						
TOTAL CDIs	75	105	50	87	70	62	61	47	47	34	44
Total Recurrence	11	20	4	19	13	5	14	6	6	8	5
% of CDI recurrence PA	15%	19%	8%	22%	19%	8%	23%	13%	13%	24%	11%

BREAKDOWN

16 (36%) of CDI episodes were hospital acquired and 28 (64%) were non hospital acquired. Non hospital CDI can be divided into Healthcare Associated Infection (HCAI), unknown and community acquired infections. Figure 4 Demonstrates the age and gender of patients with a hospital or non hospital acquired CDI.

Figure 4: Age, sex and infection by origin

	Hospital acquired infection* (*n*=16) 36.4%	Healthcare associated infection* (*n*=9) 20.4%	Community Acquired infection* (*n*=16) 36.4%	Unknown (n=3) 6.8%	Total CDI (*n*=44)
	n (%)	n (%)	n (%)	n (%)	n (%)
Male	10 (62.5)	3 (33%)	7 (44%)	1 (33%)	21 (48%)
Female	6 (37.5)	6 (67%)	9 (56%)	2 (67%)	23 (52%)
Age: mean (Range) years	72 (50-93)	55 (24-80)	58 (19-88)	73 (59-80)	65 (19-93)
Single infection	13 (81%)	8 (89%)	16 (100%)	2 (67%)	39 (89%)
Recurrent infection	3 (19%)	1 (11%)	0	1 (33%)	5 (11%)

***The origin of a CDI is defined in the Protocol for the Scottish Surveillance Programme for Clostridium difficile Infection. User Manual**

2017, Version 4.

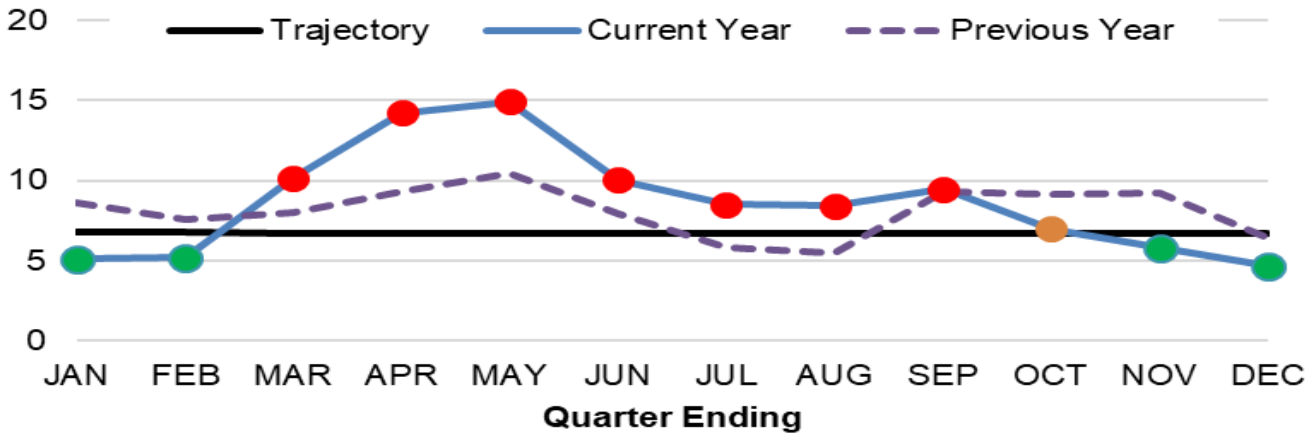
NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). All Health Boards have to achieve a 10% reduction in Healthcare associated CDI by the end of the financial year 2021/22 using 2018/19 as the base year. This requires NHS Fife to have no more than 23 Healthcare associated CDIs by 2021/22. NHS Fife is on track to achieve the target by 31st March 2022.

NOTE: Healthcare associated CDI referred to in the DL (2019) 23 include hospital acquired CDI **plus** healthcare associated CDI **plus** unknown CDIs as defined in this report.

Figure 5 demonstrates the challenge for NHS Fife to achieve the 10% reduction target by April 2022, although by December 2021, the trajectory line was met. It will remain an ongoing challenge for 2022, to further reduce Healthcare Associated CDIs, to meet the target reduction by 2022.

Figure 5 – NHS Fife 2021 CDI Quarterly rate against the Improvement Trajectory (3 months ending)



Each Fife CDI case is reviewed to ascertain risk factors for developing the infection. Figure 6 displays a breakdown of risk factors for HAI, HCAI, Unknown and CAI.
The highest risk factor is antibiotic therapy with 88.6 % of total cases and interestingly 100% of HAI, HCAI and Unknowns cases had received antibotic treatment prior to CDI diagnosis.

The second highest risk factor associated with 50% of total cases was Proton Pump Inhibitors (PPI), followed by admission to hospital within previous 12 weeks (34%), immunosupression (27.2%), gastric history (18%) and lastly recurrent infections (11.3%).

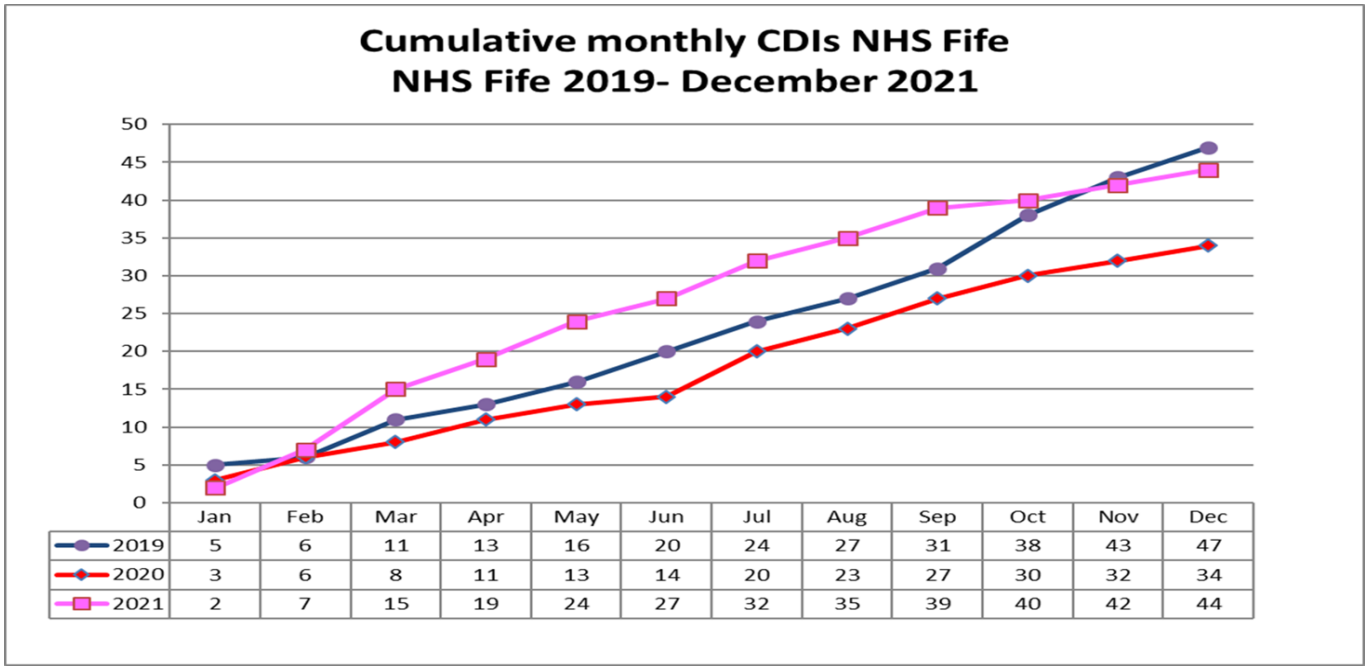
Figure 6 – CDI risk factors

	HAI (n=16)	%	HCAI (n=9)	%	Unknown (n=3)	%	CAI (n=16)	%	Total number 44	%
Antibiotic	16	100	9	100	3	100	11	69	39	88.6
Gastric history	1	6	1	11	0	0	6	37.5	8	18
Immuno supression	2	12.5	5	55.5	2	66	3	19	12	27.2
PPI	7	44	5	55.5	1	33	9	56	22	50
Recurrence	3	19	1	11	1	33	0	0	5	11.3

Trend data

Figure 7 demonstrates the annual number of *CDIs* compared to the previous 2 years. It shows that 2021 had a higher number of cases than during 2020, but an improvement in the number from 2019.

Figure 7– CDI cumulative graph for 2019-2021 for all HCAI & CAIs

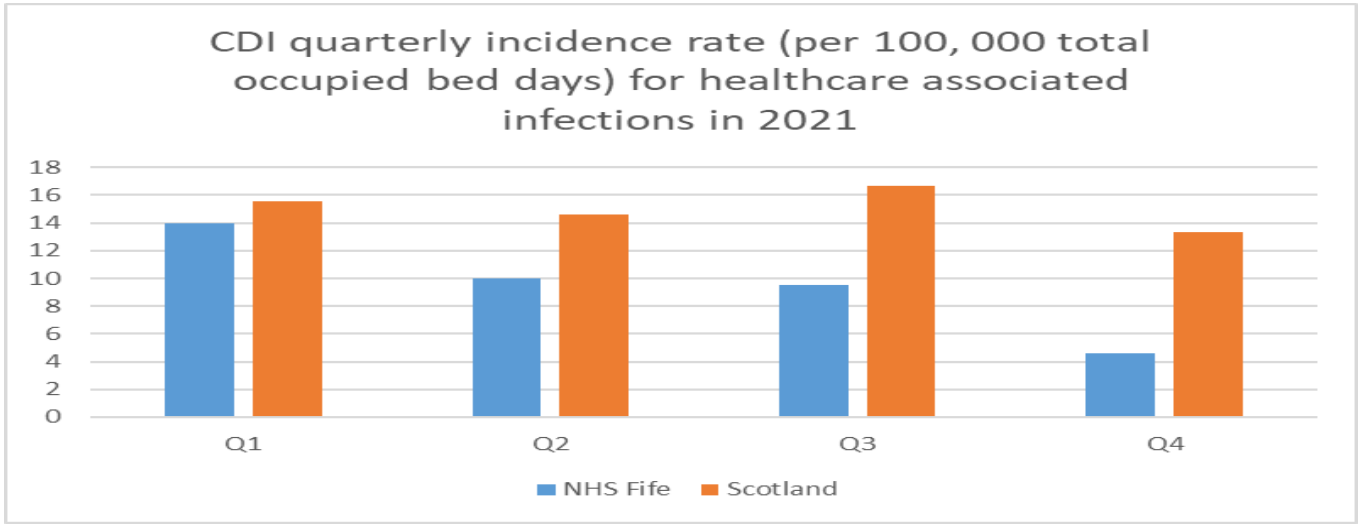


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	5	6	11	13	16	20	24	27	31	38	43	47
2020	3	6	8	11	13	14	20	23	27	30	32	34
2021	2	7	15	19	24	27	32	35	39	40	42	44

National context

At present, there is no national comparison for overall year analysis as the ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) 2021 Annual Report has yet to be published. However, considering Figure 10, it is evident that Fife has remained below the national comparator for each quarter in 2021.

Figure 10 – National comparison of Fife CDI quarterly incidence rates in healthcare associated infection cases during 2021



COMMENTS

3. Compared to 2020 there has been a 29% increase in the total number of CDI. During 2020, NHS Fife achieved the lowest annual total on record.
4. The proportion of hospital acquired CDI in 2021 was 36%
5. In 2021 there were 5 recurrences of CDI, with highest number of recurrent cases in hospitalised patients (n=3)

Dr P. Venkatesh, Consultant Microbiologist summary for 2021

Challenges identified in 2021
Recurrent CDI remains an ongoing challenge in NHS Fife.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2022
Continue stewardship advice where any inappropriate prescribing is identified.
General advice against using of quinolones wherever possible is given to both GPs and hospital doctors as part of routine antibiotic advice.

Management of recurrence of CDI for 2021 & for 2022
Patients with recurrent CDI are advised pulsed Fidaxomicin and are followed up until day 30.The use of extended pulsed Fidaxomicin (EPFX) to address recurrences have shown a good outcome.
Bezlotoxumab has been used in cases where other modalities have failed. This continues to be in place as commercial faecal transplant is still unavailable and NHS Fife who do not have provision for this locally.

Key actions for 2022
Continued surveillance and follow up all CDI cases.
NHS Fife will continue to use the EPFX regime for the high risk groups to prevent recurrence.

Appendix 3: 2021 Annual SAB Report

Annual report: *S. aureus* bacteraemias (SAB) in NHS Fife from 1st January 2021 to 31st December 2021
Dr Keith Morris, Consultant Microbiologist & Infection Control Doctor

INTRODUCTION

The report demonstrates the *S. aureus* bacteraemia (SAB) epidemiology in 2021. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *S. aureus* bacteraemias.

Data for this report has been obtained from surveillance carried out by Dr Morris & Dr Griffith. During the surveillance period there was a total of 80 SAB. 73 SAB were identified in the Victoria Hospital and four were acquired in Queen Margaret Hospital. Two patients had their *S. aureus* bloodstream infection identified in other HSCP hospitals. One patient under the care of Hospital at Home acquired a *S. aureus* bacteraemia.

The SAB epidemiology in this report occurred during the second year of the SARS-CoV-2 pandemic and must be considered in this environment. During the second year of the pandemic the Health Board has tried to maintain elective surgical program, but the pandemic has influenced the number of hospital admissions. There have been three post COVID-19 SAB. In two the entry point was a *S. aureus* ventilator associated pneumonia. There was one post COVID *S. aureus* pneumonia where mechanical ventilation was not in use.

RESULTS

Between 1st January and 31st December 2021 there were 80 episodes of SAB. 78 (97.5%) were due to MSSA and two (2.5%) were due to MRSA. Figure 1 demonstrates the trend of SAB over the previous 14 years.

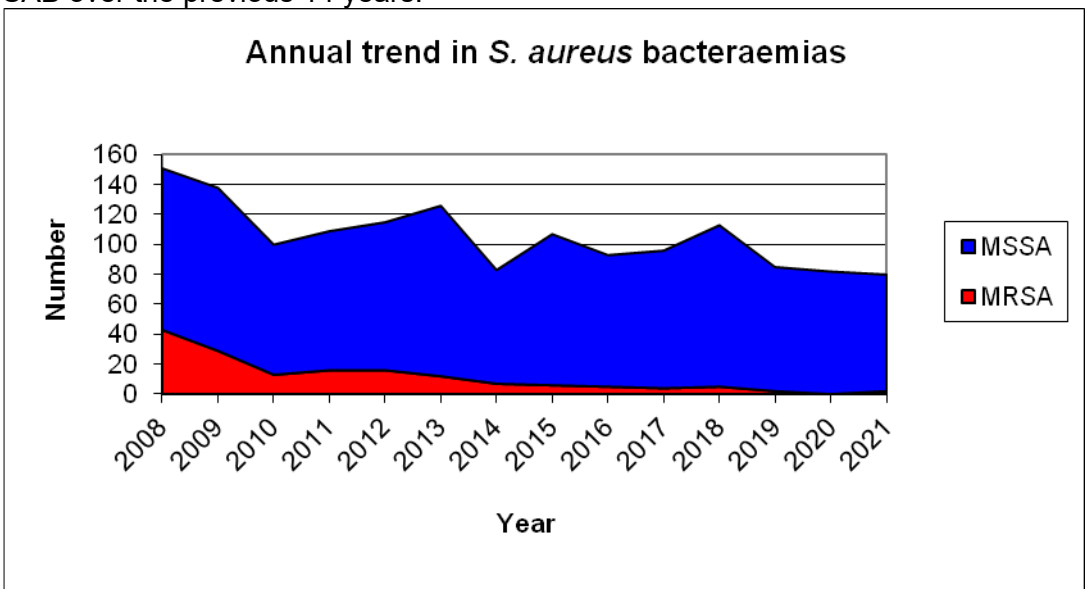


Figure 1: Trend in SAB

30 (37.5%) of SAB episodes were hospital acquired and 50 (62.5%) were non hospital acquired. Non hospital SAB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections. Table 1 Demonstrates the age and gender of patients with a hospital or non hospital acquired SAB

	Hospital acquired infection* (*n*=30) 37.5%	Healthcare associated infection* (*n*=14) 17.5%	Community Acquired infection* (*n*=36) 45.0%	Total SAB (*n*=80)
	n (%)	n (%)	n (%)	n (%)
Male	15 (50.0)	9 (64.2)	20 (55.5)	44 (55.0)
Female	15 (50.0)	5 (35.8)	16 (44.5)	36 (45.0)
Age:mean (Range) years	57.4 (40-94)	68 (0-95)	73.2 (5-95)	66.2 (0–95)
MRSA	0 (0)	1 (7.1)	1 (2.7)	2 (2.5)
MSSA	30 (100)	13 (92.9)	35 (97.3)	78 (97.5)

Table 1 Age, sex and susceptibility to meticillin of each SAB by origin

*The origin of a SAB is defined in the Enhanced *S. aureus* Bacteraemia Surveillance Protocol April 2016, Version 1.0

Figure 2 presents data on the entry point of each hospital acquired SAB during 2021.

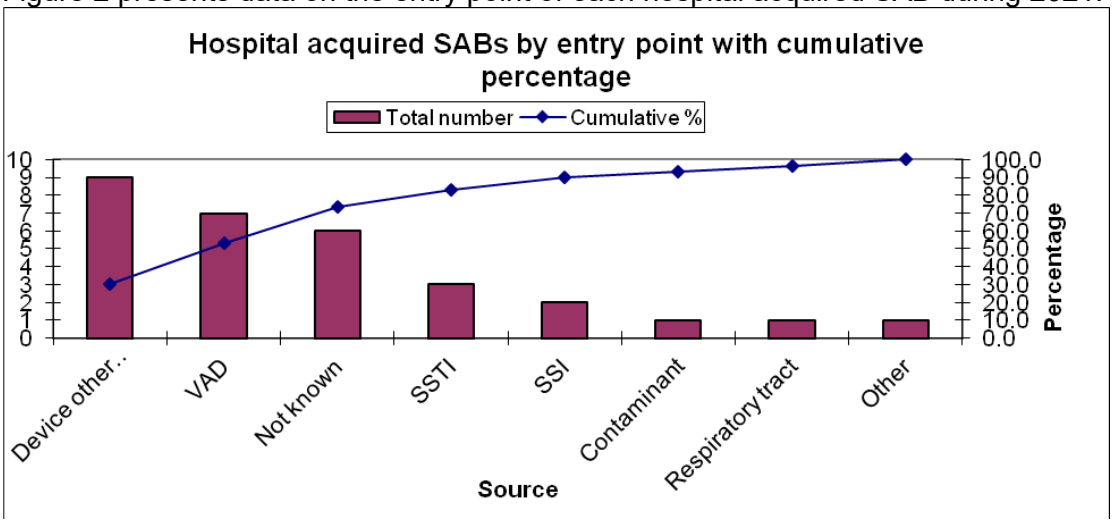


Figure 2: Pareto chart demonstrating the entry point of each hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection.

More detail on the source of each SAB can be found in appendix 1.

Figure 3 provides a breakdown of the different types of vascular access device for every hospital acquired SAB episode where a VAD was identified as the entry point for the bacteraemia.

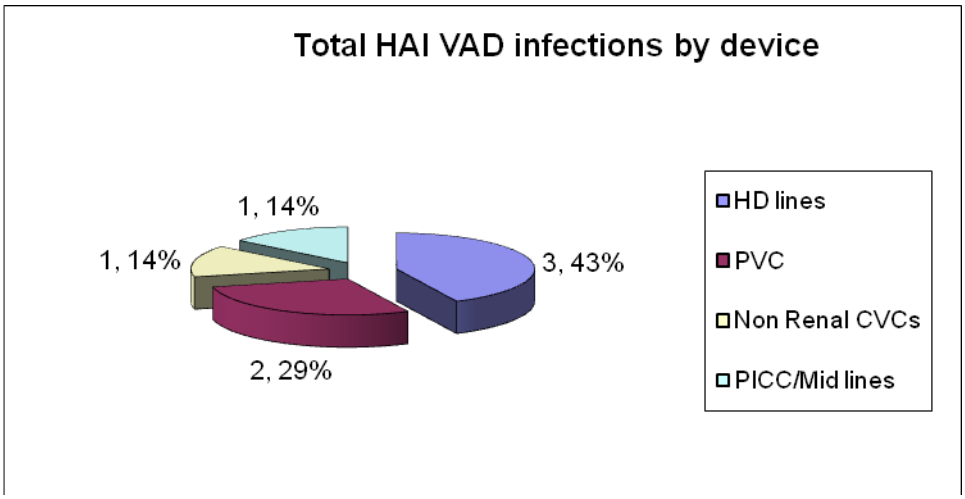


Figure 3: Types of VAD infection in 2021. PVC=peripheral vascular catheter, HD=haemodialysis, CVC-central venous catheter. PICC=peripherally inserted central catheter

Figure 4 demonstrates the trend in hospital acquired SAB over the last six years in relation to the entry point for the bacteraemia.

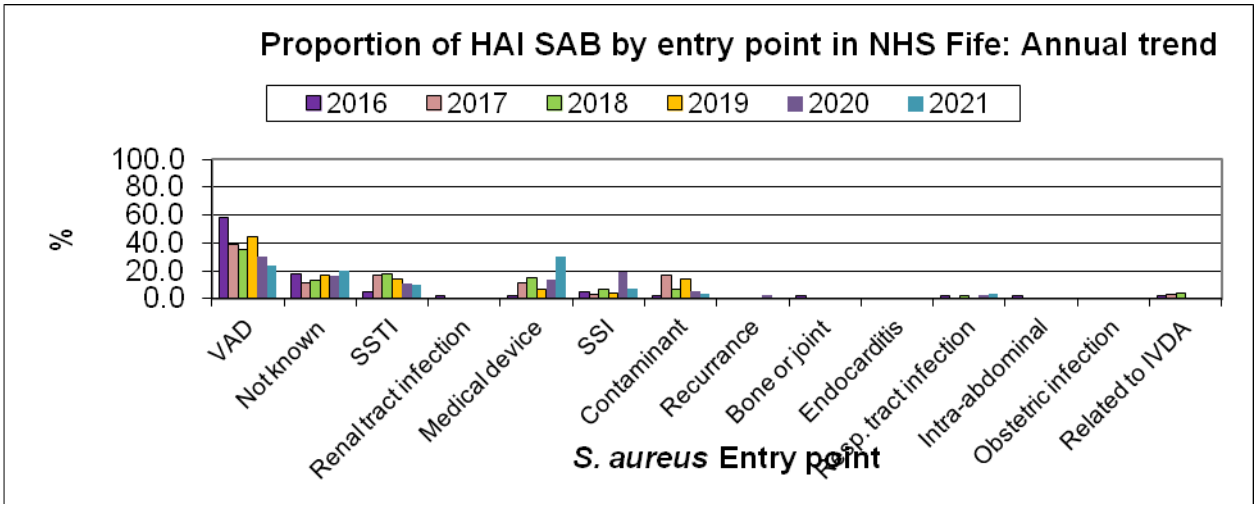


Figure 4: Trend in the entry point of hospital acquired SAB over six years. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection, SSI=surgical site infection

Figure 5 presents data on the entry point of each non hospital acquired SAB episode during 2021.

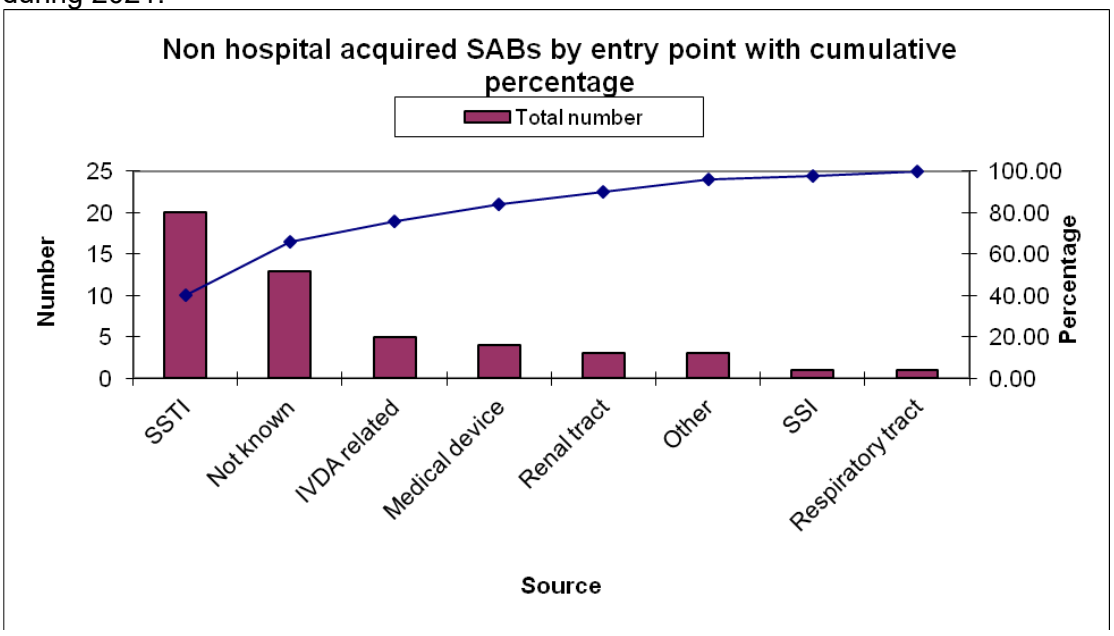


Figure 5: Pareto chart demonstrating the entry point of each non hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified,.

COMMENTS

1. Compared to 2020 there has been a 2.4% decrease in the number of SAB. This is the lowest annual total on record.
2. In 2021 there were two MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.

3. The proportion of hospital acquired SAB in 2021 was 37.5%
4. The proportion of VADs resulting in a hospital acquired SAB in 2021 was 30%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. Two SAB were associated with PVC. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug remained stable at 5 episodes in 2021. The same number as 2020
7. Figures 2 & 5 indicate the areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices and non-VA medical devices, skin & soft tissue infections plus people who inject drugs.
8. SAB where the entry point is not known remain a significant problem and accounted for 23.75% percent of the total in 2021

LOCAL TARGETS SET BY ICC

	Local targets first set in 2014	Review end 2020	Review end 2021
1	Meticillin resistant *S. aurues* to be ≤5% of total *S. aureus* bacteraemia.	No MRSA bacteraemia **Target achieved**	No MRSA bacteraemia **Target achieved**
2	Vascular access device SAB to be ≤35% of hospital acquired SAB.	29.7% of HAI SAB due to VAD **Target achieved**	23.3 % of HAI SAB due to VAD **Target achieved**
3	Total number of PVC related SABs to be halved compared with 2013. (Total in 2013 was 12)	Three PVC SAB **Target achieved**	Three PVC SAB **Target achieved**

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). All Health Boards have to achieve a 10% reduction in Healthcare associated SAB by 2021/22 using 2018/19 as the base year. This requires NHS Fife to have no more than 66 Healthcare associated SABs by 2021/22. NHS Fife is on track to achieve the target by 31st March 2022.

NOTE: Healthcare associated SAB referred to in the DL (2019) 23 include hospital acquired SAB plus Healthcare associated SAB discussed defined in this report.

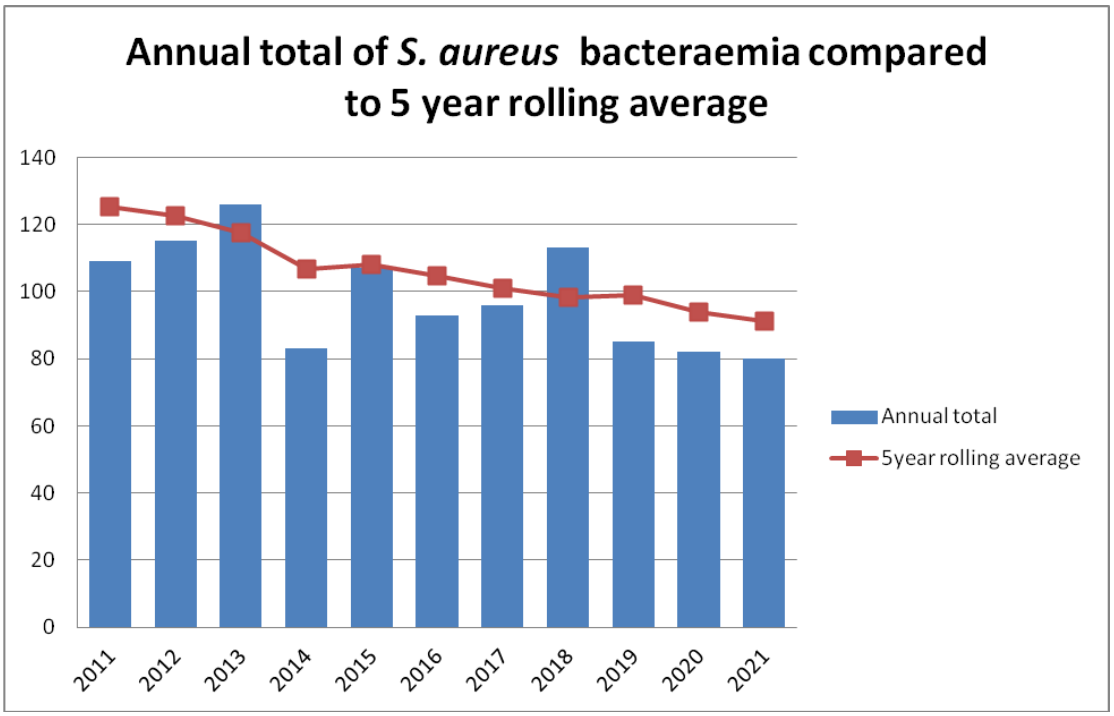
Appendix 1
Entry point for each SAB episode by origin

	Hospital acquired infection (n=30)	%	Healthcare associated infection (n=14)	%	Community acquired infection (n=36)	%	Total SABs by source (n=80)	%
Source								
Not known	6	20.0	4	28.6	9	25.0	19	23.8
Vascular access device		0.0		0.0				0.0
Haemodialysis CVC	3	10.0	0	0.0	0	0.0	3	3.8
PVC	2	6.7	0	0.0	0	0.0	2	2.5
CVC	1	3.3	0	0.0	0	0.0	1	1.3
PICC/Midline	1	3.3	1	7.1	0	0.0	2	2.5
Medical device other than VAD								
Urinary catheter	4	13.3	1	7.1	0	0.0	5	6.3
VAP	4	13.3	0	0.0	0	0.0	4	5.0
Nephrostomy	1	3.3	1	7.1	0	0.0	2	
Pacemaker	0	0.0	0	0.0	1	2.8	1	
SSTI								
Skin break		0.0		0.0	6	16.7	6	7.5
Ulcer	3	10.0		0.0	5	13.9	8	10.0
Abscess		0.0	1	7.1	2	5.6	3	3.8
Ezcema		0.0	1	7.1	3	8.3	4	5.0
Cellulitis					2	5.6	2	2.5
Other		0.0		0.0	1	2.8	1	1.3
Surgical site infection								
Superficial	2	6.7		0.0			2	
Deep		0.0	1	7.1			1	
Bone or joint infection		0.0		0.0		0.0		0.0
Miscellaneous								
Renal tract		0.0	1	7.1	2	5.6	3	3.8
Respiratory tract	1	3.3	1	7.1		0.0	2	2.5
Related to IV drug abuse		0.0		0.0	5	13.9	5	6.3
Contaminant	1	3.3		0.0		0.0	1	1.3
Other	1	3.3	1	7.1		0.0	2	2.5
Recurrence		0.0	1	7.1		0.0	1	1.3
Total	**30**	**100.0**	**14**	**100.0**	**36**	**100.0**	**80**	**100.0**

Appendix 2
Trend data

Chart 1 demonstrates annual number of *S. aureus* blood stream infections compared to the five year rolling average. Identifies the long term trends set against the spikes and troughs of individual years. Using the 5 year rolling average a subjective judgement can be made on the Health Boards performance in any one year.

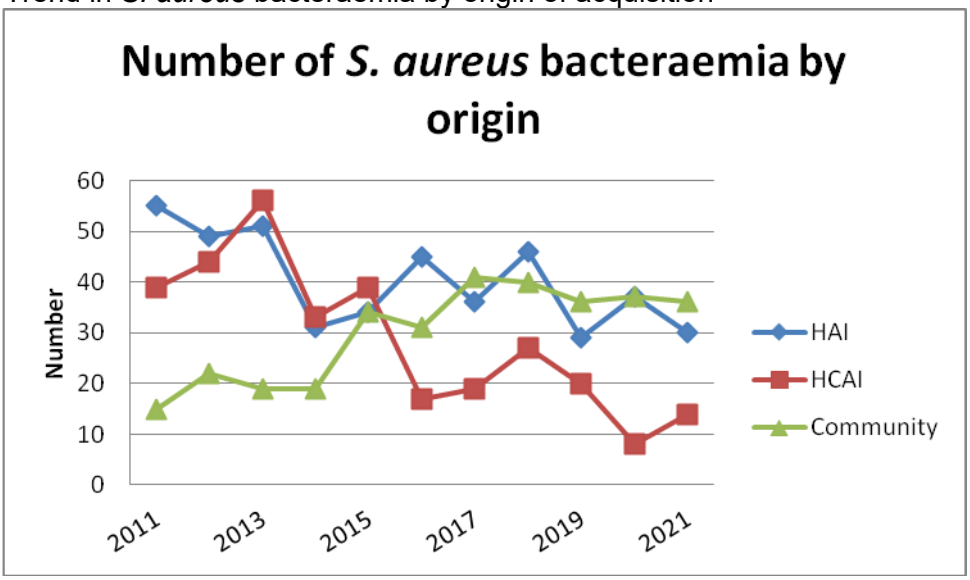
Chart 1: Fife year rolling average of SAB against annual total



Total number of SAB per annum	Performance rating
≥100	Poor
90-99	Average
80-89	Very good
70-79	Excellent

Chart 2 demonstrates the trend in *S. aureus* blood stream infection acquisition by patients and the healthcare sector which requires targeting to reduce the total annual number of *S. aureus* bacteraemia.

Chart 2: Trend in *S. aureus* bacteraemia by origin of acquisition



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Controlled Drugs Accountable Officer Annual Report - October 2022**
Responsible Executive:	**Ben Hannan, Director of Pharmacy and Medicines / Controlled Drugs Accountable Officer**
Report Author:	**Geraldine Smith, Lead Pharmacist Medicines Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The purpose of this report is to update the committee on the work ongoing to ensure the safe and effective use of controlled drugs (CDs) within Fife. The detail captured in the report demonstrates the multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes. This report covers the period April 21 to March 2022

2.2 Background

The roles and responsibilities of Controlled Drugs Accountable Officer (CDAO), and the requirement to appoint them, are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013. The CDAO is responsible for the management and safe use of CDs, for monitoring systems, and taking action where appropriate, and to ensure co-operation between responsible bodies. There is a legal duty to share information between bodies such as health boards, private hospitals and hospices, the Care Inspectorate, NHS Scotland Counter Fraud Services and the police. It is a requirement for all NHS Board CDAOs to establish a Local Intelligence Network (LIN) to support information sharing

2.3 Assessment

2.3.1 Quality/ Patient Care

The annual report can be found attached as Appendix One.

Throughout, the Controlled Drugs Accountable Officer annual report refers to quality of patient care and ensures where learning has been identified actions are taken and learning shared.

2.3.2 Workforce

The report highlights the support available to the workforce to enable safe practice. A learning culture is embedded through the detail reported to the CDAO.

To support the workforce with compliance with CD regulations a number of presentations and supporting documents have been developed and are available on staff BLINK , or sent direct to General Practice, community pharmacies and care homes.

2.3.3 Financial

There are no direct budgetary concerns

2.3.4 Risk Assessment/Management

The annual report details the efforts taken by the CDAO and team to minimise risk associated with Controlled Drugs in Fife. Policies and procedures for operational use of CDs form part of the Safe Use of Medicines Policy and Procedures.

2.3.5 Equality and Diversity, including health inequalities

There is no requirement for an assessment of this nature currently.

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement, and consultation

The attached report details communication, engagement, and consultation with multiple agencies both internally and external to NHS Fife.

2.3.8 Route to the Meeting

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

- Pharmacy Senior Leadership Team on 3rd August 2022
- CD Governance group 23rd August 2022
- Area Drug and Therapeutics Committee 12th October 2022
- Executive Directors Group 20th October 2022

2.4 Recommendation

The committee are asked to consider this report for **assurance** regarding operation of responsibilities of the Controlled Drug Accountable Officer in Fife.

.

3 List of appendices

The following appendices are included with this report:

- Appendix One - Controlled Drug Accountable Officer Annual Report - October 2022

Report Contact
Geraldine Smith
Lead Pharmacist Medicines Governance
Geraldine.smith3@nhs.scot

Controlled Drugs Accountable Officer Annual Report

October 2022

Contents

1. Purpose of Report

As a Health Board, NHS Fife is required to appoint a Controlled Drugs Accountable Officer (CDAO). The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The CDAO is responsible for the following in relation to Controlled Drugs:

- governance
- obtaining and receiving
- storage and access
- prescribing
- dispensing and supply
- destruction
- transport
- stationery
- reporting and learning
- the operation of Local Intelligence Network.

The purpose of this report is to update the Committee on the work ongoing to ensure the safe and effective use of Controlled Drugs (CDs) within Fife. The detail captured in the report demonstrates the multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes.

The report covers the period from **April 2021 to March 2022.**

2. Governance

In NHS Fife, the Director of Pharmacy and Medicines also fulfils the role of Controlled Drugs Accountable Officer for NHS Fife.

Scott Garden served as NHS Fife's Controlled Drugs Accountable Officer until 13th February 2022.

Benjamin Hannan is now registered as NHS Fife's Controlled Drugs Accountable Officer, with Healthcare Improvement Scotland (HIS). The Controlled Drugs (Supervision and Management and Use) Regulations 2013 mandate that "*HIS must compile, maintain and publish from time to time, in such manner as it sees fit, a list of accountable officers of designated bodies in Scotland."* Benjamin commenced as Controlled Drugs Accountable Officer on 14th February 2022.

Standard Operating Procedures (SOPs) and policies in place covering all aspects of Controlled Drugs management in NHS Fife and these are regularly reviewed and form part of our Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) document. A programme of audit and assurance is overseen by the Safer Use of Medicines Group, which reports to the Area Drug and Therapeutics Committee (ADTC). Details on the assurance assessments undertaken in the reporting period are found later in the report.

3. Controlled Drugs Assurance Assessments

A comprehensive programme of Controlled Drugs Assurance Assessments ensures that every ward/department holding controlled drugs in NHS Fife receives a pharmacy led visit, to assess compliance with legal and best practice requirements.

A comprehensive 66-point assessment is undertaken jointly by a member of the nursing team with a pharmacy professional. The outcome of the assessment informs compliance against the following procedural requirements for controlled drugs – storage and access, obtaining and receiving, dispensing supply, transporting and stationery.

Standardised methodology for completion of this assessment is in place and forms part of the SSUMPP document. Due to COVID-19 pressures, one cycle of assessments was completed in 2021-22, with 103 areas assessed by February 2022. The assessment splits 66 questions into 7 domains, which are broadly aligned to the CDAO responsibilities (see table one).

Table 1 – Alignment of assurance assessment to CDAO requirements

Domain	Section Header	Storage and access	Obtaining and receiving	Dispensing and supply	Transporting	Stationery
1	CD cupboard					
2	Key security					
3	CD Record Book					
4	Patient's Own CDs					
5	Requisition entries					
6	Stock check					
7	Liquid CD check					

Of note, mechanisms for seeking assurance regarding other requirements (destruction, prescribing, reporting and learning, and the operation of the CD Local Intelligence Network) are covered separately in this report

Following the assurance assessment, an individualised action plan for each area/ward/de. is recorded and implemented by the Senior Charge Nurse (SCN) or equivalent. Risk is stratified against the severity of non-compliance, and recorded on the DATIX system – using Major, Moderate and Minor as descriptors.

Of 103 areas assessed, only one area was noted to have a major concern reported; at the time of the assessment, it was noted that a patient's medicine was missing. Following

investigation, this was the result of an administrative error, and a Local Adverse Event Review (LAER) was conducted to ensure appropriate learning.

Four areas were recorded as having moderate concerns, with local improvement action plans implemented. Moderate concerns were due to the number of potential issues identified at the assessment.

A detailed breakdown of findings per domain can be found below – it should be noted due to the comprehensive nature of the assessment, only five of 103 areas were noted to be of concern; the detail below and variation across all settings is due to the scrutiny applied in reviewing each area individually.

a. CD Cupboard

Cupboards were all found to be locked, and in working order. A small number of assessments noted that non-controlled drugs were being stored in CD cupboards and this was rectified. Advice was also given to four areas to ensure high strength-controlled drugs were segregated within cupboards. The largest area for improvement was noted to be maintenance of stock lists: 16 areas were advised to update their stocklists, and 38 areas had not had a review of their stocklist in the last 12 months. The pharmacy team have taken action to rectify this.

b. Key Security

Keys were found to be securely stored away from other ward keys in all but two areas. Controlled drug stock should be checked twice daily at nursing handovers. The assessment involved reviews of records for the previous six months and noted that 30 of the 103 areas had missed at least one of the twice daily mandated stock checks or had not recorded key handover appropriately. The need to complete this record at each shift change is highlighted at time of audit, and these findings have been highlighted to Heads of Nursing.

Advice was given to 14 areas to ensure they were recording weekly checks regarding the security of duplicate/spare keys for cupboards. All areas were noted to retain spare keys in a secure place with limited access.

c. CD Record Book

All areas were found to store CD record book securely. 22 areas were given advice on how to appropriately record balance transfers between books. Administrative errors were noted across a number of different recording requirements; however no significant concern from any individual error was raised.

d. Patient's Own CDs

All areas that used Patient's Own CDs stored their record book appropriately. A few administrative errors were noted in the use of these books. Improvement action was noted in 16 areas regarding transferring of Patient's Own CDs. Main improvement actions were:

- to ensure each page has the required information recorded including name of drug and formulation recorded
- to complete details of whether patients own were transferred/ destroyed or given back to the patient.

e. Requisition entries

Across the sample there were a small number of administrative errors noted (e.g., missing signatures) – however advice was given to each area to rectify.

f. Stock Check

Aside from the major error noted previously, no concerns were highlighted through the stock check section of the assessments.

g. Liquid CD Check

All areas were fully compliant with standards in this section of the assessment

4. Destruction of Controlled Drugs

Destruction of controlled drugs is covered by the CDAO regulations. Appropriate SOPs are in place for the destruction of CDs and for the removal and destruction of illicit substances from patients. The process ensures that unwanted CDs awaiting destruction are recorded, not stored for an excessive length of time, and do not accumulate. Appropriate records are made when CDs are destroyed, and processes are in place for witnessing the destruction and disposal of stock CDs. The CDAO authorises individuals who can witness the destruction of stock CDs. In the reporting period, 75 authorised witness visits were undertaken by the pharmacy team.

5. Prescribing

Prescribing reports are available and reviewed by the Lead Pharmacist for Medicines Governance to monitor prescribing of CDs across Fife. Prescribers are contacted where further information is required. Support is given with any recommended actions to address any concerns.

'*More'* reports are generated where individual patients are prescribed above the Scottish average quantity. Individual prescribers are asked to review the patient, the clinical indication and to review quantity prescribed. Any concerns by the CDAOs team are noted and actioned accordingly.

Fife is a recognised outlier under national therapeutic indicators (NTIs) in opioids and gabapentinoids and has a higher-than-average involvement of such medicines implicated in drug related deaths. This has led to the establishment of the High-Risk Pain Medicines (HRPM) programme, a three-year patient safety programme with respect to the prescribing. This includes CDs such as opioids, benzodiazepines and gabapentinoids. It was recognised that there was a need to develop a whole system approach to managing pain to assure that the prescribing and use of these medicines is safe and effective, engendering collective responsibility and culture change in how these medicines are initiated, monitored, and reviewed to ensure patient benefit, safety, and reduction in patient harm as well as consideration of the expansion of non-pharmacological strategies for managing pain.

Monthly progress reports from the HRPM programme go via the Executive Directors Group (EDG) Portfolio Board, and a detailed report will go via standing committees 2023.

6. Reporting and Learning

Significant events involving CDs are dealt with as part of the Adverse Events Process. The CDAO works closely with the Medical Director and Director of Nursing regarding incidents of this nature.

Fife demonstrates an open culture that encourages reporting of CD related incidents. This is illustrated by a good reporting rate of incidents, with a low proportion of harm. 370 CD incidents were recorded via DATIX in the reporting period, an increase of 33 from the previous year.

Of note:

- 272 incidents were recorded as no outcome in terms of harm
- 67 incidents were recorded as minor outcome in terms of harm
- 21 incidents were recorded as moderate outcome in terms of harm
    - 4 of these incidents were CD audit records
    - 5 of these incidents involved stock discrepancies.
    - 7 involved patients not receiving prescriptions
    - 3 patients received the wrong medicine, with one of these incidents resulting in hospital admission
    - 1 patient was prescribed an incorrect dose; the patient came to no harm
    - 1 patient was accidentally given a duplicate prescription; the patient came to no harm.
- 10 incidents were recorded as major outcome in terms of harm
    - 9 of these incidents were due to missing stock. These incidents are investigated following procedures, with escalation as appropriate.
    - 1 incident involved an incorrect dose being prescribed; however, the patient came to no harm as it was not dispensed.

The CDAO also receives reports from other sources including from community pharmacies, of which there are 86 across NHS Fife.

For a detailed breakdown of the incident reports received by the CDAO see Table 2.

Table 2 – Breakdown of incidents reported to the CDAO

Issue Type	20/21	21/22	Location Type	20/21	21/22
Administration	131	141	**HSCP**		
Stock discrepancy	41	43	Care Home	0	2
Dispensing/supplying	72	95	Com. Pharmacy	109	153
CD Register discrepancy	53	54	GP	2	9
Inappropriate destruction	16	18	UCSF	6	4
Ward CD audit	29	47	Wards	123	161
Prescribing	25	27	Patient's home	18	17
Recording	6	13	**Acute Services**		
Spillage	44	34	Wards	171	159
Storage and transportation	15	13	Pharmacy	13	8
Suspicion of criminality	4	10			
Other	6	18			
Drug(s) Involved	**20/21**	**21/22**	**Source**	**20/21**	**21/22**
Alfentanil/Fentanyl	35	45	Care Home	0	1
Benzodiazepines	12	20	Com. Pharmacy	105	142
Gabapentin/pregabalin	13	21	DATIX	337	370
Methadone/Buprenorphine	60	76			
Methylphenidate/Lisdexamphetamine	15	13			
Morphine	88	74			
Oxycodone	132	172			
Tramadol	4	7			
Various	19	16			
Other	35	22			
NA- involved in ward CD audit	29	47			

Source: the organisation/department/event from where the incident or concern originate

Issue Type: (predefined list) - types of issue or concern

Location Type: (predefined list) - where the incident or concern took place

Drug/s Involved: name of top eight drugs involved, 'Various' = multiple drugs involved, "Other"

Incidents and concerns for this period have undergone local investigation and resolution. During this period there have been examples where information has been shared between responsible bodies including the police, Counter Fraud, private establishments, other Health Board CDAOs, the Care Inspectorate and regulatory bodies. Of the incidents

involving ‘suspicion of criminality’, some have been subject to police or Counter Fraud Services investigation.

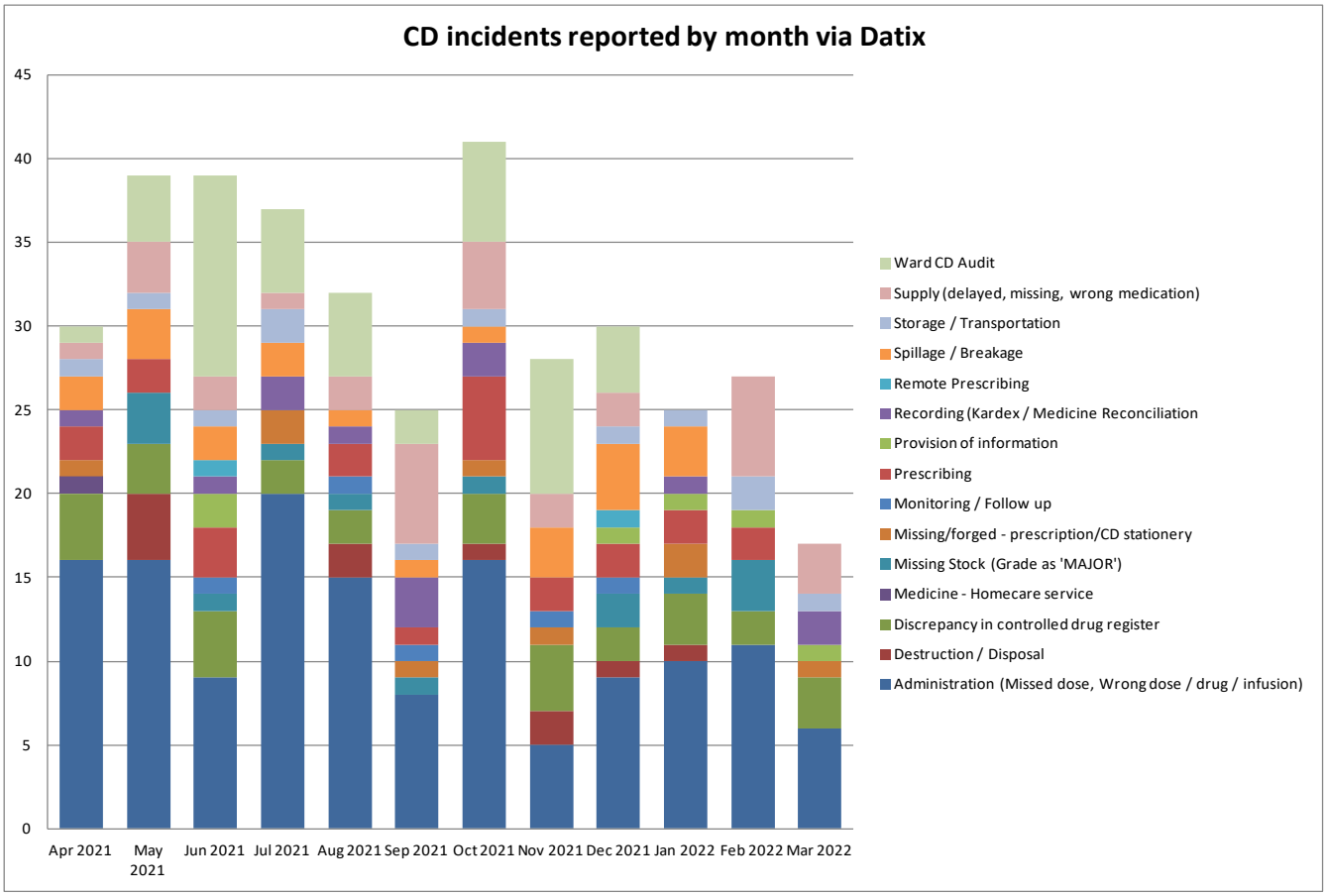
There was an increase in reporting of CD incidents both from community pharmacy and via Datix in 21/22 compared to the previous year. Reporting however is still lower than in 2019/20 figure of 579. Most types of incidents increased over this reporting period in line with the increase in incidents reported.

a. Managed Service Incidents

There was no change in the top eight drugs involved in incidents. Oxycodone continues to be the most reported drug followed by Morphine. Medicine safety huddle education and awareness sessions continue with a focus on common errors and the safer administration of medicines, specifically highlighting the difference between oxycodone and morphine.

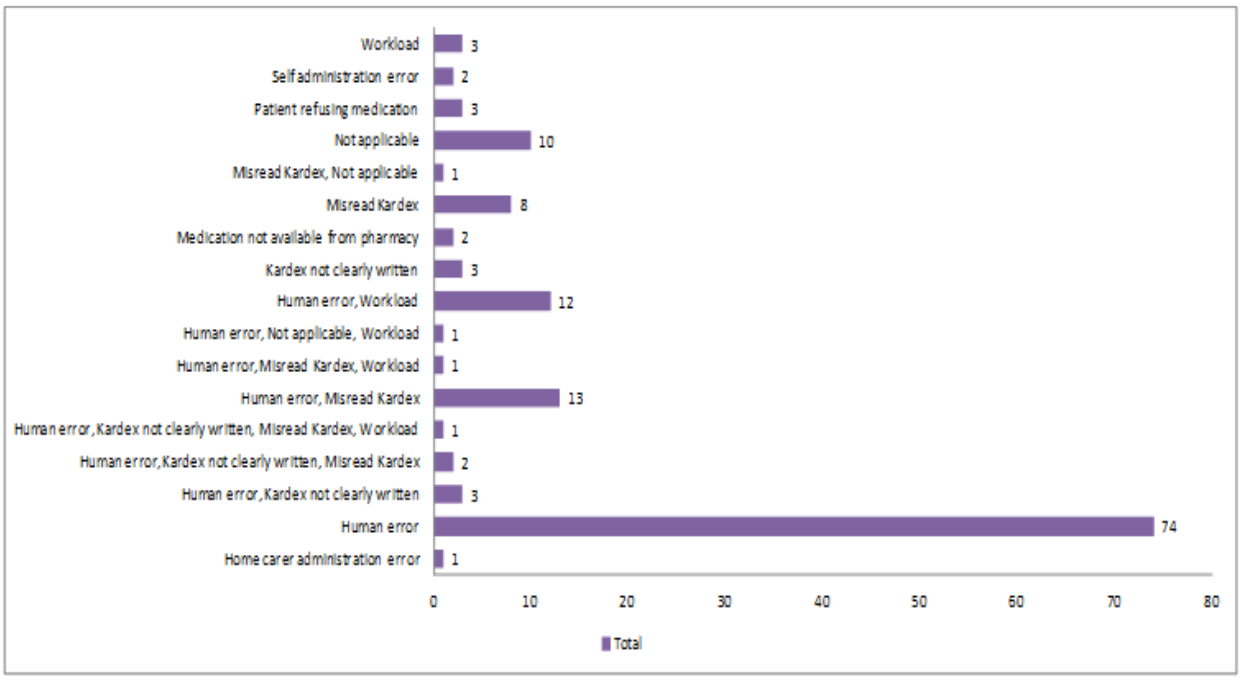
There has also been continued reduction in reporting of transportation/ storage incidents, with only 12 reported via Datix. An internal transportation audit was conducted in 2019, which highlighted areas for improvement. These were addressed in a detail action plan which has now been closed by internal audit. An internal transportation audit will be completed during 2023

Graph 1 shows CD incidents reported via Datix by month



Administration incidents remain the most reported incident type.

Graph 2 shows the reasons recorded by staff



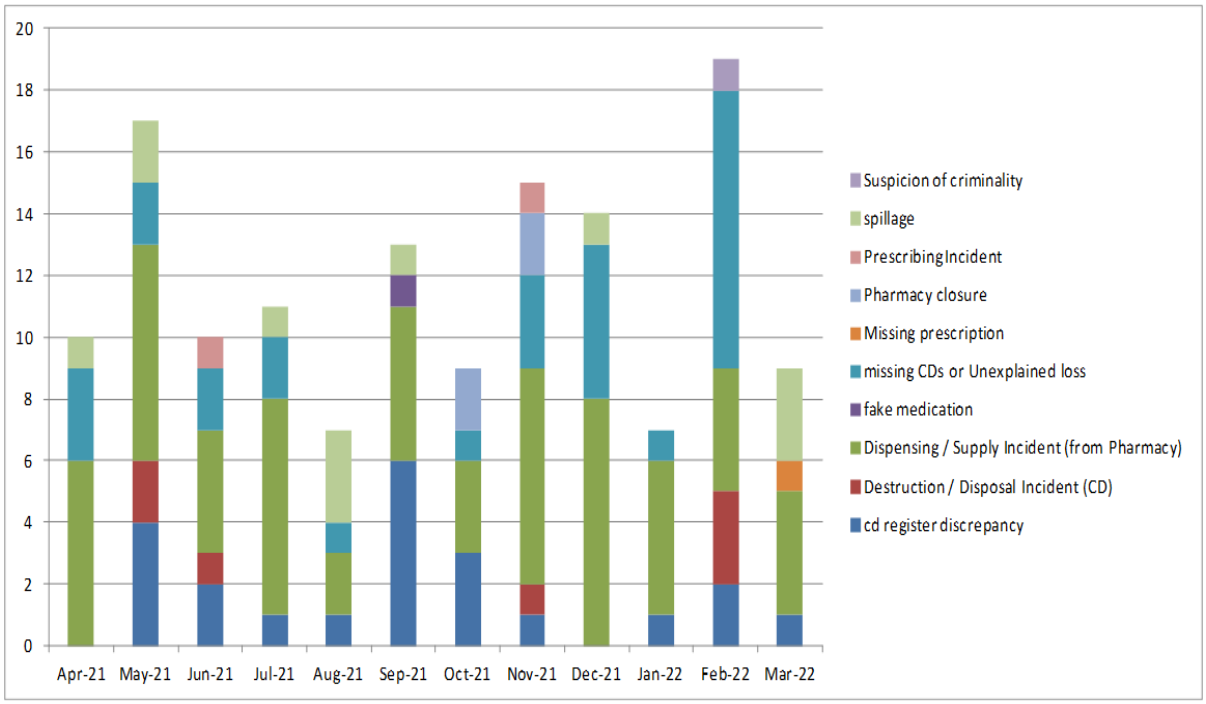
Human error is the most common reason recorded against this field. A practice development tool is available to enable staff to review practice in their area. A guide to correct selection of morphine and oxycodone was also developed to support staff with administration. There are also several educational resources available on StaffLink.

b. Community Pharmacy Incidents

Community Pharmacies in Fife must report CD related incidents to the CDAO.

Methadone is still the most common medicine reported in incidents from community pharmacy. Guidance was issued to community pharmacies regarding dispensing instalment prescriptions and reminding them of legal requirements for prescriptions as well as best practice guidance before making a supply. There has been an increase in reporting of gabapentin/pregabalin dispensing errors. An analysis of the incidents was completed and learning from the incidents will be shared in a CD bulletin.

Graph 3 shows the breakdown of incidents reported by Community Pharmacy



Dispensing and supply incidents remain the most reported incidents by community. It is important to note, no harm was caused to patients. Analysis of these incidents show procedural deviations as the root cause.

Reporting of CD register discrepancies also increased, attributed to infrequent balance checks being undertaken because of staff shortages and workload. Assurance is always sought at the time of the reporting of the incident that weekly balance checks will restart, with checks also at point of dispensing. This is followed up to ensure there are no other issues.

Temporary pharmacy closures were recorded where CD supply to patients was affected. New guidance has been developed for community pharmacies regarding unplanned closures and is monitored daily due to current staffing pressures. This ensures disruption is minimised, as any closures are communicated with GP practices, community pharmacies and addictions services with alternative arrangements put in place for patients. No further incidents have been reported since November 21.

7. Controlled Drugs Local Intelligence Network

An East Region Controlled Drugs Intelligence Network (CD LIN) was chaired by NHS Fife in May 2021. NHS Fife delivered a presentation on cluster review procedures for drug related deaths and the role of the multi-disciplinary drug death review group. Information was subsequently shared across the three boards as to how each board process works and any shared learning. Trends and themes from CD incidents were shared and work is in progress to produce a bulletin to share themes and learning from events.

A second regional CD LIN was arranged for November 21. NHS Fife presented to discuss how information is shared between boards. NHS Fife is supporting national improvement work to ensure information regarding CDs can be shared more readily between boards and external agencies, through development of a national information sharing agreement.

NHS Boards continue to share alerts where there have been fraudulent attempts to obtain medication from community pharmacy and GP practices. These alerts are then shared with NHS Fife community pharmacies and GP practices to raise awareness.

The General Pharmaceutical Council, who regulate community pharmacy, carry out inspections of community pharmacies on a rolling programme over a 36-month period. Inspections were paused during the pandemic and restarted in May 21, with a focus on new premises and where standards had not been met in previous inspection reports.

Inspection reports are available to the public to view on GPhC website. A GPhC Inspector meets with the CDAOs team on a quarterly basis to share any concerns/themes.

NHS Fife participate in the CD Accountable Officers Network (CDAON), which meets quarterly to develop detailed policies and documentation, and to develop and implement CD regulations and legislation. Peer review sessions are included in the programme. NHS Fife supports the network by reviewing documentation, sharing NHS Fife policy and procedures and support peers with advice and guidance.

The Care Inspectorate has powers to seek self-declarations about how care homes manage and use CDs. The CDAON reviews the information collected annually to inform improvement work and to promote information sharing. The Care Inspectorate also shares information in real time where there is a particular concern, while NHS Fife support with investigation and recommendations and share any learning. For example, a communication was sent to care homes to remind them of NHS Fife 'Just in Case' policy and that all CDs that are required to be stored in a CD cabinet should be removed from the just in case box, entered in the CD register and stored safely in an appropriate CD cabinet. A reminder was also sent to community pharmacies to discuss with care homes whether a 'Just in Case' box will fit into CD cabinet or if a separate bag is required for safe and secure storage of CDs.

The Care Inspectorate continues to work closely with the CDAON to support effective communication and national monitoring of CDs, and improved practice in the care sector.

8. Controlled Drugs Accountable Officer Workplan

A workplan for continued improvement of management of CDs has been developed.

Priorities for the coming 12 months are:

- Establishment of a CD governance group to strengthen scrutiny and assurance for the Accountable Officer. The membership will lead the completion of an organisational assessment on processes and procedures and levels of assurance they provide.
- Implement peer review processes across wards and departments to support continued assurance.

- Develop a bulletin for Community Pharmacy with key themes and learning from incidents reported locally and nationally.
- Review the Controlled Drugs Assurance Assessment tool to better align this to the CDAO responsibilities.
- Review the inspection model for GP practices.
- Issue self-assessment questionnaires to all Dental Practices in Fife.
- Launch a new ward CD register, developed nationally, which has an improved index and recording of part used CDs.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**4 November 2022**
Title:	**Volunteering Annual Report 2021-22**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience**

1 Purpose

The purpose of this paper is to introduce the NHS Fife Annual Volunteering Report 2021 - 2022 to the Committee.

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Government policy / directive
- Local policy

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

- Person Centred

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

- Well informed
- Appropriately trained & developed
- Treated fairly & consistently, with dignity & respect, in an environment where diversity is valued
- Provided with a continuously improving & safe working environment, promoting the health& wellbeing of staff, patients and the wider community

2 Report summary

2.1 Situation

This report covers the period from April 2021 to March 2022 and provides a flavour of work undertaken during this time and describes plans as the service moves forward.

2.2 Background

NHS Fife recognises the invaluable work of our volunteers. The huge commitment and dedication to our NHS, patients, and the public alike are experienced every day by the work that our volunteers do in their various roles across all our sites and in each service.

Fife volunteers come from various backgrounds and from across the whole of Fife. Our volunteers want to make a difference in the recovery and care of everyone using health services and as such volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day.

Volunteering also offers the volunteer a new challenge, a new focus for those retired or who have the experience to share and offer others in similar situations.

2.3 Assessment

The last 12 months have continued to be challenging for our volunteering services; balancing the benefit to our hospitals with the risk, and the expectations of our volunteers. Volunteering services and our volunteer managers have worked hard to keep volunteers engaged, informed, and supported throughout.

Many of our volunteers were ready, willing, and excited to return once allowed, and we gradually started the remobilisation of our volunteers. Our Volunteer Managers worked hard to redefine roles, explore opportunities, and manage risks so our volunteers were able to return.

Whilst the April 2021 to March 2022 period heralded the start of the remobilisation of previously stood-down volunteers, it was also marred by setbacks such as the Omicron variant which saw volunteer roles suspended once again, to help reduce the footfall within the hospitals to protect patients and volunteers alike. Ward-based volunteering was also further impacted in Spring 2022 by localised closures to bays and wards due to further infection control measurements requirements.

As part of a National reporting exercise to the Scottish Government, in the period between October 2021 and March 2022 (inclusive), NHS Fife recorded an average of 24 volunteers delivering over 1,500 hours of support across Acute and Community Hospitals.

STAFF GOVERNANCE STANDARD

STRAND	LINKAGE
Well informed	The Volunteering in NHSScotland Programme, delivered by Healthcare Improvement Scotland (HIS), drives forward the volunteering agenda in NHSScotland through effective leadership, governance, consultancy and expert advice for volunteering across NHSScotland. They have a range of publications providing information, guidance and good practice.
Appropriately trained & developed	In response to the pandemic there has been a shift towards a digital first approach to training. The Volunteering in NHSScotland Programme, together with National Education Scotland, developed a Once for Scotland approach to volunteer induction training, with a dedicated module now hosted via TURAS

Treated fairly & consistently, with dignity & respect, in an environment where diversity is valued	We are unable to adequately monitor our equality and diversity characteristics due to the limitations of the national Volunteer Information System, however anecdotal evidence suggests an increase in youth volunteering and BAME representation. The service is now exploring other electronic solutions to allow secure and meaningful collection of equality monitoring data.
Provided with a continuously improving & safe working environment, promoting the health& wellbeing of staff, patients and the wider community	Scottish Governments Scotland's Volunteering Action Plan, June 2022, seeks to build upon the Volunteering for All Framework; the Action Plan seeks to maximise the impact of volunteering. It aims to create an environment and a community of practice in which volunteering can adapt to changing priorities and continue to thrive.

2.3.1 Quality / Patient Care

Our volunteers want to make a difference to the recovery and care of everyone using health services and, as such, volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day

2.3.2 Workforce

There has been change in the staffing complement within the Volunteering Team. The team, had consisted of three Volunteer Leads in post (2.8 WTE) supported by an administrative assistant (0.48 WTE). As a result of retirement, the team now consists of two Volunteer Leads (1.8 WTE). In recognition of the high level of administrative tasks involved in the service, the administrative support has increased to full time, with one administrative assistant (1.0 WTE). The service reports directly to the Head of Patient Experience (HoPE).

2.3.3 Financial

Funding – Whilst there is designated funding volunteering service workforce team, there is no dedicated source of funds for the everyday running of the service for items such as uniforms, thank you cards, postage, volunteer expenses and celebratory events such as the annual Volunteers Week and Christmas. To date funding has been ad hoc via both NHS Fife charities fund and individual ward endowments. To support and grow the service, and acknowledge the significant impact volunteers have within NHS Fife, a dedicated source of recurring funding is being sought.

2.3.4 Risk Assessment / Management

During this time the Volunteering Service has faced several challenges including workforce changes, remobilisation, and the ever-changing landscape of the COVID-19 pandemic and associated infection control and prevention measures. Infection Control and Prevention education modules are available and have been recommended by the Infection Prevention and Control Team.

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

Volunteering within NHSScotland is supported by Scottish Government's, Volunteering for All, Our National Framework, April 2019. The Framework sets the direction for Scotland's approach to volunteering over the next decade by focusing first and foremost on the

volunteer, rooted in our national values of kindness, dignity and respect. It highlights and recognises the changes required to break down barriers to volunteering and to create more diverse and inclusive opportunities for everyone to engage in throughout their life.

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement and consultation

Annually NHS Fife take part in recognising and celebrating our volunteers across National Volunteers Week, 1-7 June. Due to the pandemic we were unable to gather volunteers to mark the occasion, however this was acknowledged through thank you cards and a series of social media posts highlighting and thanking our volunteers.

Steering Group – With a new Head of Patient Experience (HoPE) in post, it is an opportune time to relaunch a volunteering steering group to aid development, raise the profile of the service, and strengthen governance and assurance.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development.

- EDG 20 October 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- NHS Fife Volunteering Annual Report 2021 - 2022

Report Contact
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Head of Patient Experience
Email siobhan.mcilroy@nhs.scot

NHS Fife

Volunteering Annual Report

2021-2022

Foreword

NHS Fife recognises the invaluable work of our volunteers. The huge commitment and dedication to our NHS, patients, and the public alike are experienced every day by the work that our volunteers do in their various roles across all our sites and in each service.

NHS Fife volunteers come from various backgrounds and from across the whole of Fife. Our volunteers want to make a difference in the recovery and care of everyone using health services and as such volunteers bring an enormous contribution to the health and wellbeing of staff and patients, enhancing everyone's experience of health every day.

Volunteering also offers the volunteer a new challenge, a new focus for those retired or who have the experience to share and offer others in similar situations. Our volunteers are supportive and find a shared purpose in their new relationships with each other as well as being able to learn new skills. Volunteers bring as much to our services as they can do to the volunteers' life. NHS Fife is keen to explore and build on these positive achievements by working with local communities to support their return to work, personal development, and community development.

The last 12 months have continued to be challenging for our volunteering services; balancing the benefit to our hospitals with the risk, and the expectations of our volunteers. Volunteering services and our volunteer managers have worked hard to keep volunteers engaged, informed, and supported throughout.

Many of our volunteers were ready, willing, and excited to return once allowed and we gradually started the remobilisation of our volunteers. Our Volunteer Managers worked hard to redefine roles, explore opportunities, and manage risks so our volunteers were able to return.

We are delighted to have our volunteers back with us working and look forward to continuing to grow and develop this service within NHS Fife. We cannot emphasise enough the value of their commitment and contribution to NHS Fife.

Siobhan McIlroy
Head of Patient Experience

Introduction & Summary

This Annual Report for NHS Fife Volunteering Service covers the financial period between 1 April 2021 to 31 March 2022 and details the volunteering activity throughout this period.

During this time the Volunteering Service has faced several challenges including workforce changes, remobilisation, and the ever-changing landscape of the COVID-19 pandemic and associated infection control and prevention measures.

Whilst the April 2021 to March 2022 period heralded the start of the remobilisation of previously stood-down volunteers, it was also marred by setbacks such as the Omicron variant which saw volunteer roles suspended once again, to help reduce the footfall within the hospitals to protect patients and volunteers alike. Ward-based volunteering was also further impacted in Spring 2022 by localised closures to bays and wards due to further infection control measurements requirements.

As part of a National reporting exercise to the Scottish Government, in the period between October 2021 and March 2022 (inclusive), NHS Fife recorded an average of 24 volunteers delivering over 1,500 hours of support across Acute and Community Hospitals.

National Guidance & Policy

Volunteering within NHSScotland is supported by Scottish Governments, Volunteering for All, Our National Framework, April 2019. The Framework sets the direction for Scotland's approach to volunteering over the next decade by focusing first and foremost on the volunteer, rooted in our national values of kindness, dignity and respect. It highlights and recognises the changes required to break down barriers to volunteering and to create more diverse and inclusive opportunities for everyone to engage in throughout their life.

Scottish Governments Scotland's Volunteering Action Plan, June 2022, seeks to build upon the Volunteering for All Framework; the Action Plan seeks to maximise the impact of volunteering. It aims to create an environment and a community of practice in which volunteering can adapt to changing priorities and continue to thrive. It seeks to establish accountability for ensuring that the needs of volunteers are at the centre of future decision-making.

NHS Fife's current policy was last reviewed in April 2021, with the next refresh due no later than April 2024. It is hoped however that the associated NHS Fife Volunteer Expenses Procedure is reviewed ahead of this time to reflect a national decision to increase the mileage rate for volunteers, as this has not been amended by Scottish Government for over 10 years. Volunteer Leads are conscious of the impact of the increased cost of living on our volunteers, and apprehensive that this may become a

barrier to entry for some. The Volunteering in NHSScotland Programme are taking this agenda forward with Scottish Government.

Workforce & Support to Volunteering Services

There has been change in the staffing complement within the Volunteering Team. The team, had consisted of three Volunteer Leads in post (2.8 WTE) supported by an administrative assistant (0.48 WTE). As a result of retirement, the team now consists of two Volunteer Leads (1.8 WTE). In recognition of the high level of administrative tasks involved in the service, the administrative support has increased to full time, with one administrative assistant (1.0 WTE). The service reports directly to the Head of Patient Experience (HoPE).

The Volunteering in NHSScotland Programme, delivered by Healthcare Improvement Scotland (HIS), drives forward the volunteering agenda in NHSScotland through effective leadership, governance, consultancy and expert advice for volunteering across NHSScotland. They have a range of publications providing information, guidance and good practice. The programme offers a package of support to volunteer managers with peer networking sessions, practice development sessions and access to their 'volunteering helpdesk' for support, alongside a virtual Volunteering Community of Practice.

NHS Fife Volunteer Leads have taken part in various development groups with the programme to influence outcomes with the proposed new Volunteer Information System (VIS) and review of the NHSScotland Volunteer Induction Module hosted via TURAS.

Fife Voluntary Action (FVA) are our local Third Sector Interface (TSI) who provide good practise guidance, training and networking opportunities for the volunteering team and are a means of promoting volunteer opportunities and recruitment locally.

Remobilisation

The COVID-19 pandemic has led to significant changes in volunteer management practice in NHSScotland. Working with HIS, and to Scottish Government guidelines, the Volunteering Service, together with NHS Fife colleagues across Health & Safety, Infection Prevention & Control, Human Resources and Occupational Health & Wellbeing, developed a Standing Operating Procedure for the Remobilisation of Volunteers after COVID-19 and supporting documentation. This has been continuously changing with regards to national guidelines change to reflect shielding, immunisation status, lateral flow testing, mask wearing and social distancing.

A number of the previous volunteer cohort have re-engaged with us through remobilisation process, and subsequent training provided. Roles which have remobilised include play volunteers, ward helpers and meaningful activity volunteers. This has seen the return of the weekly singing group at Queen Margaret Hospital, hosted by a long standing volunteer.

Volunteering within the palliative care service is yet to resume as a result of the closure and refurbishment of the Victoria Hospital based hospice, and the change of service delivery within ward 16 hospice provision at Queen Margaret Hospital.

Some volunteers have however taken this opportunity to retire for many reasons; including change of circumstances, age, own physical health/health concerns and necessity to wear face masks.

During this period of time recruitment has re-opened with a limited number of opportunities available; balancing the needs of clinical services and risks.

Training & Development of Volunteers

In response to the pandemic there has been a shift towards a digital first approach to training. The Volunteering in NHSScotland Programme, together with National Education Scotland, developed a Once for Scotland approach to volunteer induction training, with a dedicated module now hosted via TURAS. This has been invaluable to NHS Fife to provide a remote and flexible means of delivering volunteer specific content, not only new recruits, but as part of the remobilisation training for those returning post pandemic. Infection Control and Prevention modules are also available and have been recommended by the Infection Prevention and Control Team (IPCT).

There is of course a need to apply this approach in a measured way; assessing the suitability of a digital first approach within different volunteer demographics; recognising gaps in information technology (IT) literacy, learning styles and access to technology. In order to maximise inclusion, when online learning is not appropriate a blended approach of face to face training is delivered by the Volunteer Leads and/or by IPCT.

Volunteer Demographic

NHS Fife Volunteering Services presently has 52 volunteers across 6 sites (Victoria Hospital, Queen Margaret Hospital, Adamson Hospital, Cameron Hospital, Glenrothes Hospital and St Andrews Hospital) along with 9 public partner volunteers currently engaging with groups virtually across NHS Fife.

We are unable to adequately monitor our equality and diversity characteristics due to the limitations of the national Volunteer Information System, however anecdotal

evidence suggests an increase in youth volunteering and BAME representation. The service is now exploring other electronic solutions to allow secure and meaningful collection of equality monitoring data.

Role Development

Alongside our existing roles which have remobilised, the service has welcomed a number of new developments.

Our existing "Meet and Greet" volunteers have supported the International Recruitment Programme by offering a tour of the Victoria Hospital to each incoming cohort of international recruits as part of their initial orientation programme.

To support the newly refurbished Fife Simulation Training and Education Centre at Queen Margaret Hospital, volunteers have been recruited to act as simulation patients; assisting in staff and student training sessions; participating within directed role play as a "patient" within healthcare based scenarios.

A number of new public partner volunteers have been welcomed to NHS Fife to support within the Cancer Governance & Strategy Group and the Cancer Services Single Point of Contact Hub Project Group.

Volunteers & NHS Fife Community Listening Service

Our Community Listening Volunteers continue to provide an important service to the population of Fife. As we moved out of the pandemic a number of our long serving volunteers took the opportunity to "retire" and we are grateful for all they have done and the commitment to Community Listening Chaplaincy (CCL). Between the 1st April to the 30th September 2022 CCL received 494 referrals and provided 629 listening sessions.

We currently have 19 active listeners providing CCL in 14 GP Practices and to the Improving Cancer Journey Project. In the summer we ran the National Formation Course where 2 new listeners were identified for NHS Fife. It is our hope that the 2 new volunteers will be appointed in autumn 2022.

CCL in Fife started almost a decade ago as a national demonstrator project. Over the years NHS Fife has been at the forefront of developing CCL and the use of volunteers. Up until now, the cost of providing CCL has been met from a slight under spend in the Department of Spiritual Care's core funding (usually from vacancy) and allocating a Healthcare Chaplain (5 hours per week) to support the volunteers and coordinate the service. However, as services remobilise we see a significant increase for Chaplains to support staff. As such, without dedicated funding or resources, CCL may have to cease in March 2023.

Celebrating Volunteering

Annually NHS Fife take part in recognising and celebrating our volunteers across National Volunteers Week, 1-7 June. Due to the pandemic we were unable to gather volunteers to mark the occasion, however this was acknowledged through thank you cards and a series of social media posts highlighting and thanking our volunteers.

"Esther started this week and she has been fab! For such a young girl she has just come into the ward and got stuck in. The staff are already very impressed with her. It's such a boost to the ward having the volunteers in".
(Senior Charge Nurse, Cameron Hospital)

"Volunteering over these past 10 months before going off to university has been an incredibly rewarding experience which has allowed me to learn and grow in confidence. The skills I have been taught and developed will always be with me as I move forward towards my medical career. Thank you for your support and for taking me on in the first place - I've loved every second of it!!"
(Meet & Greet and Ward Helper Victoria Hospital)

"The return of volunteers to the ward has been another step towards normality after the last few years. Volunteers bring something extra to the ward, someone for patients to talk to that is not connected to their medical care, a different face. Wards are busy places and staff do not always have 15 minutes to sit with someone who needs a chat and a friendly face, a bit of reassurance and their mind taken off their worries, but the volunteers do. They provide an invaluable service that has been hugely missed, everyone on the wards were delighted to see their return and for them to become part of the team again."
(Lead Nurse, Queen Margaret Hospital)

"The staff in the hospital are so appreciative of your help and support. They make me feel like what I'm doing is worthwhile, and that gives you a positivity and a bit of a buzz...it gives you a purpose, it energises you, you're mixing with other people, you're learning things. People have their own stories and their own experiences and I feel I get as much out of it as the people I'm trying to help get out of it... it's a win win situation"
(Patient Experience Volunteer, Victoria Hospital)

"Wow it is challenging to quantify ALL the benefits volunteers bring to the Unit. All my experiences of working with volunteers have been extremely positive, we (NHS Fife and departmentally) benefit from the wealth of knowledge and experience volunteers bring. An important one for us is play delivery in the play areas, Meg involves the children and families in arts/crafts, this not only engages them in the activity it reduces their anxiety, increases the parent and child interaction, making their hospital visit FUN rather than a scary worry, this in turn leads to an improved consultation as many health professionals have told me. As a health playworker I feel really lucky to have a volunteer who really is in tune with me, the values and benefits of play and is always trying to improve the children's hospital journey."
(Health Playworker, Queen Margaret Hospital)

Moving Forward 2022-23

Funding – Whilst there is designated funding for payroll of the volunteering service workforce there is no dedicated source of funds for the everyday running of the service for items such as uniform, thank you cards, postage, volunteer expenses and celebratory events such as the annual Volunteers Week and Christmas. To date funding has been ad hoc via both NHS Fife charities fund and individual ward endowments. In order to support and grow the service, and acknowledge the significant impact volunteers have within NHS Fife, a dedicated source of recurring funding is being sought.

Steering Group – With a new Head of Patient Experience (HoPE) in post it is an opportune time to relaunch a volunteering steering group to aid development, raise the profile of the service, and strengthen governance and assurance.

Reach & Roles – As detailed in this report the current spread of the volunteering service is not Fife Wide, with a notable absence within Mental Health Services. Once remobilised volunteering has been embedded, this is an area that requires review.

Associated Documents/Links

- Volunteering in NHSScotland Programme Annual Report 2021-22;
  Annual Report 2021-22 | HIS Engage
- NHS Fife Volunteering Policy;
  Volunteering Policy | NHS Fife
- Volunteering for All: National Framework;
  Volunteering for All: national framework - gov.scot (www.gov.scot)
- Scotland's Volunteering Action Plan;
  Volunteering action plan - gov.scot (www.gov.scot)

CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Covid-19 Update							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
General Covid-19 Update	**Director of Public Health**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Assurance Statements from sub-committees	**Board Secretary**	✓					
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg – CGOG not met yet**	**Deferred to next mtg**	✓			✓
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Board Assurance Framework - Quality and Safety	**Medical Director / Director of Nursing**	✓	✓	✓	**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**				✓		
Strategy / Planning							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Clinical Governance Framework	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to next mtg**	**Deferred to Nov '22**		✓		✓
Clinical Governance Framework Delivery Plan	**Medical Director / Associate Director of Quality & Clinical Governance**				✓		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Cancer Strategy	**Medical Director**					**TBC**	
Data Loch	**Medical Director / Associate Director for Research, Development & Innovation**	**Deferred to next mtg**	✓				
Emergency / Resilience Planning	**Director of Public Health**	✓	✓				
Governance of Advanced Practitioners	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**				✓		✓
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**				

Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Quality / Performance (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
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**			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Volunteering Report	**Director of Nursing**				✓ **Annual 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**			✓	
Annual Resilience Report	**Medical Director**	**TBC**					
Clinical Advisory Panel Annual Report	**Medical Director**		✓				
Digital and Information Annual Report	**Associate Director of Digital & Information**					✓	

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**					✓	
Integrated Screening Annual Report *(also goes to PHWC)*	**Director of Public Health**			**Deferred to next mtg**	✓		
Medical Education Report	**Medical Director**	**Deferred to next mtg**	**Deferred to next mtg**	**Deferred to next mtg**	✓		
Medical Appraisal and Revalidation Annual Report	**Medical Director**				✓		
Nursing, Midwifery, Allied Health Professionals – Professional Assurance Framework	**Director of Nursing**		**Deferred to next mtg**	✓			✓
Organisational Duty of Candour Annual Report	**Medical Director**				**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**					✓	
Research, Innovation and Knowledge Annual Report	**Medical Director**					✓	
Review of Deaths of Children & Young People	**Director of Nursing/Associate Director of Quality and Clinical Governance**						✓ **Annual Review**

Annual Reports (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
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	✓ 18/01
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				✓ 31/08	
Cancer Governance & Strategy Group	**Medical Director**	01/04 **Mtg cancelled**		✓ 02/06		✓ 19/08 & 04/11	
NHS Fife Clinical Governance Oversight Group	**Medical Director**	✓ 15/02	✓ 19/04	✓ 14/06	✓ 16/08	✓ 18/10 & 06/12	
Digital & Information Board	**Medical Director**		✓ 19/04	✓ 28/07	✓ 18/10		
Fife Drugs & Therapeutic Committee	**Medical Director**	✓ 09/02	✓ 27/04	✓ 22/06	✓ 24/08 & 12/10	✓ 07/12	
Fife IJB Quality & Communities Committee from July 2022)	**Associate Medical Director**	✓ 04/03	✓ 20/04	✓ 05/07	✓ 09/09	✓ 08/11	
Health & Safety Subcommittee	**Chair of Sub-Committee**	✓ 11/03		✓ 10/06	✓ 09/09	✓ 09/12	

Linked Committee Minutes (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
Infection Control Committee	**Director of Nursing**	✓ 02/02 06/04 **mtg cancelled**		✓ 08/06 & 03/08		✓ 05/10 & 05/12	
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**			✓ 24/05			
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 04/03	08/04 **Mtg cancelled**	✓ 06/07		✓ 04/11	✓ 10/01
NHS Fife Medical Devices Group *(New group formed in June 2022)*	**Medical Director**				✓ 16/08	✓ 08/12	
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 31/03	✓ ~~24/05~~ 20/06		✓ 22/09	✓ 24/11	
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)**				
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**			✓			

Ad Hoc Items (cont.)							
	Lead	**29/04/22**	**01/07/22**	**02/09/22**	**04/11/22**	**13/01/23**	**03/03/23**
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**				✓		
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 Director**					**TBC**	

Acute Services Division Clinical Governance Committee

Meeting on 7 September 2022

The Committee wished to raise the following item for escalation to NHSF CGC:

LIMS (Laboratory Information Management System) SBAR

The implementation at speed of an alternative LIMS for NHS Fife poses a number of risks for the reporting of laboratory results.

This has occurred because the current LIMS supplier has withdrawn the right to use their system from 1st April 2023 as a result of them not being successful in procuring the LIMS consortium contract for 11 Boards across Scotland.

The NHS Fife Board has supported a rapid implementation to the new system, supplied by Citadel and risks are mitigated by the fact that work has begun and is progressing at pace to ensure that the system will be in place and interfaced to crucial systems (Clinical Portal, etc) by go-live in March 2023.

SLT and EDG have supported the business case for this replacement which is in the final stages of sign-off.

Regular updates will be given to SLT and EDG with escalation to ASD CGC should timelines slip.

Acute Services Division Clinical Governance Committee

A NOTE OF THE ACUTE SERVICES DIVISION CLINICAL GOVERNANCE COMMITTEE HELD ON WEDNESDAY 7TH SEPTEMBER 2022 AT 2.00PM VIA MS TEAMS

Present	**Designation**
Mrs Norma Beveridge	Head of Nursing – Emergency Care Directorate
Mrs Lynn Campbell	Associate Director of Nursing (CHAIR)
Mrs Claire Dobson	Director of Acute Services
Dr Ian Fairbairn	Clinical Director – Emergency Care Directorate (from 2.15pm – Item 4.1)
Mrs Donna Galloway	General Manager – Women, Children & Clinical Services (until 3.00pm – end Item 7.4)
Mrs Pamela Galloway	Head of Midwifery
Ms Robyn Gunn	Head of Laboratory Services (until 3.00pm – end Item 7.4)
Dr Sally McCormack	Clinical Director – Emergency Care Directorate (from 2.15pm – Item 4.1)
Mrs Kerry Perrie	Senior Nurse – Quality & Risk – Emergency Care Directorate
Ms Arlene Saunderson	Head of Nursing – Planned Care Directorate
Professor Morwenna Wood	Associate Medical Director (Interim)
Mr Satheesh Yalamarthi	Clinical Director – Planned Care Directorate

Apologies	**Designation**
Mrs Jane Anderson	Radiology Services Manager
Mrs Karen Gray	Therapy Services Manager
Mr Ben Hannan	Director of Pharmacy & Medicines
Ms Aileen Lawrie	Associate Director of Midwifery
Mrs Elizabeth Muir	Clinical Effectiveness Co-ordinator
Ms Marie Paterson	Head of Nursing – Acute Services Division

In Attendance:

Miss Lynn Godsell	PA to the Associate Medical Director & Associate Director of Nursing (minutes)

ACTION

1 Welcome and Introductions

Mrs Campbell welcomed everyone to the meeting.

Mrs Campbell noted that this was Ms Gunn's first meeting of the Committee and asked Ms Gunn if she had met those attending. Ms Gunn introduced herself and noted that she had met most of the people attending.

2 Apologies for Absence

Apologies for absence were noted from the above named members.

Mrs Campbell noted that there had been a few late apologies received and this highlighted the need for the Committee to be quorate.

Mrs Campbell advised that members will go through the agenda drawing attention to any highlights or issues by exception, noting that those present should have read the papers in advance of the meeting.

3 Unconfirmed Minute of ASDCGC Meeting held on 15th June 2022

The minutes from 15th June 2022 were approved as an accurate record.

4 Matters Arising

4.1 Action List

Action 334 – Penicillin Business Case – Professor Wood advised that Dr Bulteel is leading on a project related to Penicillin allergy de-labelling. There is a standard protocol, consent and patient info leaflet which is used across HBs. Unfortunately, she has due to workload pressures she has not managed to progress with this but there is no clear timescale at present. Regard as complete and bring back to the Committee when Dr Bulteel progresses. Add to workplan. **LG**

Action 354 – Diabetes & Endocrinology – Agenda Item. Regard as complete.

Action 382 – SAER Learn Summaries -
Ms Saunderson noted this an action for the Pain Management Service regarding the consideration for digital record keeping following an SAER action when a filing cabinet which contained handwritten patients notes went missing. In terms of this action the pain team have made a request for the introduction of Morse to support the implementation of paperless/paperlight processes moving forwards. We believe they are in the early stage of the Morse Real Time project, which the Pain Team have been identified for.

Ms Saunderson noted that there are some other departments still using handwritten notes. Mrs Campbell suggested that she follow this up as an action as there has been learning from this incident and advised that the organisation is also in the middle of a review of the Adverse Events policy and procedures. Mrs Campbell added that going forward, a digital resolution seemed sensible for a number of areas. **LC**

Action 405 – ASD CGC Workplan 2022 – 2023 – No information received. Mrs Campbell asked Directorates that this be taken as an action as it was really helpful to have a forward workplan for the Committee so we can balance when reports are presented to the Committee. Teams were requested to respond within 2 weeks.

Action 406 – Fluid Standards Report – Professor Wood advised there was no update but will meet with Dr McDougall as this is more of a Medical Education issue. Regard as complete.

Action 407 – Update re RAS – Mrs Campbell said that it would be helpful to agree a timescale for a written report being submitted to the Committee as there is a lot of good progress being made and it was important for the NHSF CGC to be aware too. Mr Yalamarthi agreed that a 6 monthly written update would be provided in future. **PCD/LG**

Action 408 – Parathyroid Surgery – Mrs Ogden had fedback to Mr Walker and the procedure. Regard as complete.

Action 409 – Directorate Report – ECD
Mrs Perrie advised that she had met with the Tissue Viability team and they have scheduled in some training for AU1 staff around the grading and recording of

pressure ulcers. Mrs Perrie added that she had begun a review of all pressure ulcers that are logged to ensure there is no duplication between Community and Acute. Regard as complete.

Action 410 – Directorate Report – ECD
Update for RCPE review is an agenda item. Regard as complete.

Action 411 – Directorate Report – ECD
Update re COVID outbreak in the Dialysis unit – agenda item. Regard as complete.

Action 412 – Directorate Report – ECD
Medicines Fridge Audit – Mrs Beveridge to contact Ms Smith. No update – c/f to November 2022. **NB**

Action 413 – Endocrinology Service Update
Covered under Action 354. Regard as complete.

Action 414 – Synaptik – Neurology
Dr McCormack has not been able to meet with Dr McKenna. Update to be brought back to the November meeting. **SMcC**

Action 415 – RAD Unit
Dr McCormack advised that this remained ongoing and as yet, there was no clear data for the RAD patient determining whether the LOS (Length of stay) is appropriate or too lengthy. Mrs Watts said that it has become apparent that the LOS for a ward actually tracks with the whole patient journey. The LOS is actually associated with Ward 9 so have requested that there is a split out of the wards and how the data is transferred rather than the historical LOS. Mrs Watts said the report will be brought to the November meeting. **ECD/LG**

Action 416 – Directorate Report – Clinical Services Report
Incorrectly labelled specimens to be included within the ECD & PCD reports.

Ms Saunderson advised that these are not included in the report but PCD have had contact with Clinical Effectiveness to determine how it can be fixed as the Directorate are not getting receipt of the correct Datix entries. Ms Saunderson said this linked in with Action 418 and Ms Saunderson had met with Dr Roy in Accident & Emergency (A&E) to talk about mirroring the processes used in A&E as these were recognised as being well embedded in the department. Mrs Campbell noted that the actions for this Committee have been addressed but said there was a further action which needs to be taken forward probably through the Performance Reviews and discussion how we take forward that piece of improvement work. Mrs Campbell said it was encouraging to hear the conversations that are taking place and some of the actions that are underway to make it more overt to the Directorate teams. **AS/RG**

Action 417 – Directorate Report – Clinical Services
Mrs D Galloway said this linked into the same piece of work as Actions 416 & 418. Mrs D Galloway added that Ms Gunn would now be able to pull the Datix stats but agreed that it was not ideal that the Datix goes back to the ward so would need to look into this. **RG**

Action 418 - Directorate Report – Clinical Services
Covered under Action 416.

Action 419 – Directorate Report – Clinical Services
LIMS – agenda item.

Actions 420 & 421 – Directorate Report – Clinical Services
Mrs D Galloway advised that Actions 420 & 421 were linked. This related to a resolution for cancelling tests on Trak and the information not filtering through to the other system. Mrs Galloway said there was now an error message which showed up on Trak but was unsure if this was being investigated any further. Comms have been sent out and Mrs Galloway will monitor progress and bring back to the Committee if further issues arise. Regard as complete.

Action 422 – Directorate Report – Clinical Services
Mrs P Galloway advised that a number of meetings have taken place but the report is still to be finalised and submitted. c/f to November 2022 **JM/LG**

Action 423 – Directorate Report – Clinical Services Report - Miss Godsell not received the weekly learning example for sharing. Mrs D Galloway to follow up. **DG**

Actions 424 & 425 – Divisional Risk Register
Mrs Campbell advised that herself and Professor Wood had looked over the Risk Register with an email being sent to the General Managers as there were a number of risks that Mrs Campbell wanted to sense check whether these were sitting on both registers (the Divisional and the Directorate) and noted that some housekeeping was required. Mrs Campbell added that an overview was presented at the recent NHSF CGC in relation to the recent updates to the Corporate risk register and this was more user friendly in terms of how it looked and easier to read. This will be fed down to other risk registers thus providing the opportunity to tidy up the relevant Risk registers. Action remains live.

5 Hospital/Board or Population Level Reports:

Scheduled Governance Items:

- **IPQR Report/s**
  June 2022

Mrs Campbell noted the IPQR reports for June and August 2022 adding that these are not discussed at length in this forum as the measures will be highlighted within the Directorate reports.

Mrs Campbell said that the IPQR's are discussed at the NHS Fife Clinical Governance Committee.

August 2022

The IPQR for August was noted.

- **Tissue Viability Annual Report/Update**

Mrs Campbell informed members that this was a regular annual report which comes to the Committee for information.

Mrs Campbell added that the Tissue Viability team is a brand new team as the former team all moved to positions in Tayside when they set up their service. Mrs Campbell noted that the team had worked hard and have done pretty well for being a new team and added that discussions are ongoing on how we can increase and strengthen the links with the Health & Social Care Partnership (HSCP) team. Mrs Campbell noted the report contained some very specific information and asked members to return any comments to Ms Paterson regarding the report content.

There were no queries raised at the meeting and the annual report was noted.

- **Consent Report – N/A – c/f to November 2022**

Ms Saunderson said that this is a piece of work which the Directorate require to proceed with. **PCD**

The Consent report will be c/f to November 2022. **LG**

- **End of Life Report/Audit – N/A – c/f to September 2022**

Mrs Campbell commented that she was unsure who owned this report. Miss Godsell said that the update was requested from Dr Kim Steele but received no reply. Mrs Campbell and Miss Godsell to sense check. **LC/LG**

- **SSR Report/Audit Update**

There was no update provided. See action list for post meeting note.

- **FOR INFO – SNBTS Transfusion Team Annual Update Report**

Mrs Campbell noted the Transfusion Team Annual report and highlighted that we have a new Transfusion Practitioner in post, Jennet Getty who is continuing to work with great gusto.

Mrs Campbell referred members to the action plan and noted that NHS Fife continues to make good progress against the specific actions.

Mrs Campbell asked if the national policy had been concluded as she was aware there was an action to integrate the national policy with our own NHS Fife policy.

Ms Saunderson responded to advise that there was now a plan to amalgamate NHS Fife Transfusion policy, Transfusion manual and the Scottish National Blood Transfusion Service (published May 21) into one policy. The expectation from SNBTS is for all Scottish Health Boards to adopt their document. For this reason an SBAR had been submitted to the clinical policy group that the updated Transfusion Policy would be updated by December 2022.

Ms Saunderson commented that there has been a lot of good work being driven forward and with having Ms Getty in post and a cohesive Blood Transfusion Committee, things are working well.

Mrs Galloway echoed Ms Saunderson's comments.

The report was noted.

6 Women, Children & Clinical Services Directorate

6.1 Directorate Governance – Specialty National Reports

There were no specialty reports submitted.

6.2 Directorate Level Outcomes Data:

- **Clinical Audit**

No clinical audits submitted.

- **SAER LEARN Summaries**

There were no LEARN summaries submitted.

6.3 Departmental Reports

- **Clinical Services Report**

Mrs D Galloway spoke to the Clinical Services Report and highlighted the following points:

- Mislabelled specimens – now having conversations with the correct people and hope to see some improvements with this.
- Increase in incorrect results for the last reporting period – this jumped from 1 to 14 incidents which is concerning. The causes for the increase were due to changes to the Standard Operating Procedure (SOP), staff training, shortage of staff and new staff who will be less familiar with the ways of working but this will be closely monitored.
- Radiation Incident – referrer error made for the wrong patient hence this has been returned to the referrer and the RCR pause procedure has been shared with the individual who will complete a reflective account of learning.
- There was one complaint for Laboratory which highlighted issues around the national changes to Cervical Cytology screening resulting in a patient waiting a significant amount of time for results. This has now been resolved. Mrs Galloway added that a National Adverse Events Review has been co-ordinated by National Services Scotland (NSS) to look at this issue as other Boards are likely to be experiencing the same issues/delays.

- **For discussion – LIMS SBAR**

Mrs D Galloway spoke to the Laboratory Information Management System (LIMS) paper.

Mrs Galloway explained that an issue was highlighted at the last Committee meeting regarding the LIMS which gives all the results on every test carried out (around 5 million tests per annum) in that the current supplier are withdrawing all services because they were not awarded the contract for the renewal of the system. Mrs Galloway added that the contract went out to tender and because the supplier lost the bid, they now intend to withdraw use of their system from 1st April 2023 so a decision had to be made whether to accept an alternative with the current supplier or bypass this company and go straight to the new supplier, Various papers were

written with the pros and cons which were submitted to the Board, with the decision being made to go with the new supplier. Work is now underway to deliver the core elements of the contract within the timescale so that the transition of supplier is smooth and users are unaware of the changeover.

Mrs Galloway advised that Senior Leadership Team (SLT) and Executive Directors Group (EDG) will be kept updated on milestones and will inform the Committee if these are not met as this will be an increased risk. Mrs Galloway noted that the Board had requested that this paper is escalated to the NHSF CGC. Mrs Galloway added that the business case to proceed with the new supplier is now complete and will be submitted to Fife Capital Investment Group (FCIG) next week enabling NHS Fife to call off the existing contract imminently.

Mrs Campbell said this was definitely a positive step and noted that a cover sheet would be prepared for the escalation to NHSF CGC in due course. Mrs Campbell asked if there was any commercial sensitivity around this paper but added that if it is being escalated then her question has been answered. Mrs D Galloway advised that Mrs Potter, Chief Executive had informed the current supplier on 19th August of the intention to cease the contract. Mrs Galloway informed members that there will be risks with the systems that are left eg: Cyberlab and test requests for GP's, hence NSS is taking legal advice around the issues. **LC/LG**

There were no questions from members around the LIMS.

Mrs Campbell then asked about the increase in Extravasation incidents during July? Mrs Galloway was unaware of any escalations but would discuss with Mrs Anderson. **DG/JA**

- **For awareness – SBAR Histology Wax Supply Problem**

Mrs D Galloway informed members about the wax supply problem and advised that the Directorate was made aware 3 or 4 months ago about a global shortage of wax, which is quite a serious issue as every Histology and biopsy specimen that the Laboratories receive requires wax for the process. Mrs Galloway said that the situation seems to have stabilised as Fife worked quickly to source an alternative supply but it may be that we will require to triage the work that requires to be done so the items of lesser clinical value will be backlogged. Mrs Galloway reassured the Committee that there would be no risk to cancer patients or urgent specimens.

Mrs Galloway will update at the next meeting if there are any changes to the situation. **DG**

The risk was noted.

- **For information – Syngo User Guide (PACS Outage)**

Mrs D Galloway highlighted to the Committee that when a PACS failure occurs, it is a major issue and to date there have been two outages since December 2021. The second outage was very short and did not cause any problems but the learning from this is that in Fife staff can see images through another system, albeit not historical images. Mrs Galloway added that the user guide describes where these workstations are in case staff need to utilise them and also how to access a log in for the system for business continuity purposes.

Professor Wood asked Mrs Galloway if it was possible for more areas to have access to the software or if there was a limit to the number of computers/licences? Mrs Galloway advised that it was a licence and questioned if we should have more resilience after having two outages. Mrs Galloway will discuss with Mrs Anderson and the PACS team and see what options are available. **DG/JA**

The update was noted.

- **Women & Children Report**

Mrs P Galloway summarised the Women & Children report.

Mrs Galloway advised that the reporting period covered April – July 2022.
Mrs Galloway noted that women can now self-refer for termination of pregnancy, using hubs as well as locally. This initiative has just begun so there was no feedback or further details to share at the moment.

There have been some challenges in the Neonatal Unit recently resulting in the unit having to be closed – this has not happened often but is due to a lack of Neonatal Specialist Qualified Nurses with some being on maternity leave and others having paused the training for a 2 year period. Mrs Galloway noted that other Boards are having the same difficulties.

Child death review meeting – Mrs Galloway said it has been recognised that there requires to be better engagement from the Procurator Fiscal.

Mrs Galloway highlighted that there were challenges within Gynaecology again with the split of the ward in Wards 24 & 54.

Mrs Galloway said that when endeavouring to complete SAERs within the required timeframe, there were delays in obtaining Post Mortem reports which has an impact on the final reports.

Mrs Galloway noted re challenges with staffing at the moment as the Clinical Risk Midwife has moved to another post outwith the Directorate. This raises ongoing challenges for the Directorate.

Mrs Galloway noted the reports which were included and asked if any required discussion. Mrs Campbell suggested that the Committee read through the reports and if any issues or queries that they get in touch with Mrs P Galloway. **All**

Mrs Campbell praised the team of nurses for winning the national award.

- **For awareness/discussion –**

- **A 11 Year Audit of Fetal Cardiac Anomaly Screening**

The report was noted.

- **Neonatal Cluster Review**

Mrs Galloway advised that the cluster review has been nationally recognised and the Scottish Government will be reviewing nationally so it is beneficial that Fife has undertaken this work in advance.

- **PPH Focus Group**

Mrs Galloway informed members that some good work has come from this focus group and added that the pathways now for Gynaecology and any women attending A&E have improved. This work resulted from a previous SAER as staff were unclear about the escalation process.

The PPH Focus group notes were noted.

- **4 Month PPH Deep Dive Poster**

The poster was noted.

6.4 Specialty/departmental audit & assurance data (incl. guidance)

- **Clinical Quality Indicators**

There were no Clinical Quality Indicators submitted.

6.5 New Interventional Procedures

Nothing for submission.

6.6 SPSO Recommendations

There were no SPSO recommendations.

7 Emergency Care Directorate

7.1 Directorate Governance – Specialty National Reports

There were no specialty reports submitted.

7.2 Directorate Level outcomes data:

- **Clinical Audit**
- **ECD Projects**

Mrs Beveridge spoke about the ECD project list and noted that the Directorate usually register 4 to 6 projects on a monthly basis but notably since July 2020 the number of projects completed and reports submitted has decreased. Mrs Beveridge asked Dr McCormack if she wished to comment on this. Dr McCormack said that it is a reflection of the workforce and activity issues too. Dr McCormack added that there is usually quite a number that are done by junior doctors and with workforce issues, the juniors often move on which can also have an impact. Dr McCormack suggested that some housekeeping is done with a view to finishing these reports off. ECD to progress. **SMcC/ECD**

Mrs Campbell thanked the Directorate for the breadth of work which is going on.

- **SAER LEARN Summaries**

There were no SAERs for discussion.

7.3 Directorate Report

Mrs Beveridge highlighted the following points from the ECD Directorate report:

Incidents
616 incidents reported during the two month period with the percentage of harm being 31% which is a slight increase. The top incidents by category are:
patient falls, tissue viability and a new one for the Directorate is infrastructure – and in particular that relates to safe staffing. Mrs Beveridge added there has been a significant rise in the numbers of incidents with a significant increase in incidents with major harm during June & July (27 compared to 15 in the previous period).

Cardiac Arrests
There was a rise in Cardiac Arrests with the Directorate reporting 13 over the last two months. These have all been reviewed though the appropriate Emergency Bleep Group process and it was encouraging to see that all except one case had appropriate action in place and were closed down. One case was recommended for an SAER.

Major Incidents
There were 14 major incidents. These related to:
6 patient falls (AU1 x 3) – AU1 has seen a notable increase in falls and this correlates to staffing shortfalls. A significant piece of improvement work recognising the challenges will be commencing in AU1 led by Wendy Hutchison, Kerry Perrie and the Senior Charge Nurses.
Falls in other areas were noted as Ward 21, Ward 41 & Ward 42.

The remaining incidents were categorised as:

- Hospital acquired pressure ulcers (ICU and WD43).
- Medication Incidents – AU1
- Other clinical events – (AU1 and Ward 6)
- SAB (Ward 42)
- Attempted suicide (Ward 23)

SAERs and LAERs
Mrs Beveridge advised that there are 48 ongoing LAERS and 13 SAERs. Mrs Beveridge complimented Mrs Perrie on doing a fabulous amount of work for the cluster reviews on common themes. Mrs Beveridge added that essentially the Directorate are still catching up these due to the COVID pause.

Mrs Beveridge noted that the team has started to test the new templates which have been issued from Clinical Governance. Mrs Perrie has been testing a few including the critical incident review form so it is hoped to have some feedback for future meetings.

Falls
There have been 180 patient falls over this two month period, of which 33 have sustained harm. The total number of falls has increased by 22 from previous reporting period which aligns with the staffing pressures within ECD over this period.

- 6 are categorised as major harm and are subject to a falls LAER.
- 5 are categorised as moderate harm and 22 are categorised as minor harm.

Ward 42 remains the highest reporter of Falls although they have very little or no harm in the ward so are an exemplar. Mrs Perrie is working with SCN Amy Fox in Ward 32 looking at a "one stop teach sheet" for patient falls on how to record them, how the ward puts plans in place to prevent falls and everyone is aware of the expectations of them for a patient who is deemed high risk. Mrs Beveridge commented that this will be helpful.

Tissue Viability
There has been a total of 104 pressure ulcers reported; of which 28 were hospital acquired pressure damage, a slight reduction on previous reporting period. 3 Grade 3's reported (2 x LAER, 1 Pending Decision). Mrs Perrie is carrying out a piece of work with AU1 who reported a high number, now has access to the community tissue viability data and has developed a swift process when a Datix is received regarding tissue damage in AU1, Mrs Perrie can refer to the community data and correlate the information and AU1 has seen a 50% reduction in moderate damage during the reporting period so this is working well.

Ward 9 and Ward 34 have reported an increase in incidents in moderate and major harms. Mrs Beveridge commented that this may be connected to length of stay (LOS) particularly in Ward 9 and the increase in medical patients boarding in Ward 34. The Directorate will continue to monitor this closely.

Medication Incidents
There have been 60 reported medication incidents over this two month period prescribing and administration of medication being the top categories. Mrs Beveridge noted a number of these took place in AU1, so the Directorate are now carrying out a cluster review/LAER to look at Medicines reconciliation and prescribing processes in AU1. Feedback will come to the Committee in due course. Mrs Beveridge added that there are concerns that Locum and agency staff in AU1 remains high which influences the policies and processes being followed directly. **ECD**

Infrastructure
Mrs Beveridge spoke about Infrastructure and informed members that there has been a significant increase for these incidents. The Directorate reported 70 incidents during the period compared with 40 in the previous period. Mrs Beveridge said that on review, 13 of these were reported due to over-capacity and the OPEL score and 51 related to concerns over staffing levels/staffing ratios and skill-mix. Mrs Beveridge said that she believed there was a direct correlation to the overall pressures currently faced within Emergency Care and in particular the impact of low staffing levels at ward level and the increase due to the increase in using supplementary staff notably bank and agency staff. Mrs Beveridge added that throughout this reporting period the front door staff have reported excessive waiting times and key areas being over-capacity with an impact on patient care. This will be monitored closely. Mrs Beveridge was aware that discussions take place widely within the organisation about the infrastructure issues.

Mrs Beveridge asked members for any questions.

Mrs Campbell said that she welcomed the increase in reporting and would always

encourage staff to do this when there is a complement of staff they feel uncomfortable with in their respective areas. Mrs Campbell added that she was aware there was lots of work going on around this issue but this Committee was not the forum for detailed discussion.

Mrs Campbell made a couple of observations and noted the rise in cardiac arrests and there is work ongoing and are aware form the daily huddle that the Obs on time is proving challenging but it is critical as these are the sick patients and any delay to Obs on time is concerning.

Mrs Campbell said that not to minimise the severity of the incidents but added that the organisation would never achieve zero falls in a hospital with elderly and frail patients but welcomed the focus in AU1 to reduce the falls with harm.

Mrs Beveridge assured the Committee that herself, the General Managers, Service Managers participate in a monthly review of the Directorate Risk Register. Mrs Beveridge added that the new templates will be welcomed.

Mrs Campbell thanked Mrs Beveridge for the work that has been picked up as a result of the measures within the report and noted this was a helpful overview.

7.4 Specialty/departmental audit & assurance data (incl. guidance)

- **Clinical Quality Indicators**
- **RCPE external Review report – Neurology – Update**

Dr McCormack mentioned that this report was as a result of an independent review of the NHS Fife Neurology service commissioned by Dr McKenna. The review focussed on:

- Capacity and demand of the service as well as
- Variation of the service compared to other areas in Scotland
- Address any perceived tensions between the service delivery team and the management team

The report produced by the Royal College of Physicians of Edinburgh was confidential and not for general circulation, so respecting the people involved a full copy of that report will be sent to the two co-chairs of this Committee. **ECD/SMcC**

Dr McCormack advised that she had prepared a brief summary noting the suggestions and findings from the report highlighting that two workshops had already taken place with both clinical and management teams and a third was scheduled imminently. The workshops provide the opportunity to improve and transform the Neurology service in Fife and the Directorate also intend to benchmark the department against other national groups. The benchmarking will look at specific things such as bed base for seriously unwell patients, job plans and future models of care.

Dr McCormack noted the significant piece of work and suggested that an update be brought back to a future Committee meeting. Dr McCormack agreed to advise Miss Godsell of the timeframe and will add this to the workplan. **SMcC/LG**

The update was noted by members.

- **KardiaMobile Update**

Mrs Campbell advised members this item had been a direct request from Dr McKenna for inclusion of this work.

Dr McCormack provided a verbal update noting that NHS Fife have 12 devices split over two sites, however on asking for a full breakdown of numbers, Cardiology administration do not have an accurate recorded numbers of the devices fitted so there is no up to date information available on the success of the devices. Dr McCormack added that, going forward, the team will carry out a prospective audit and that will be submitted back to the Committee in due course.

Mrs Campbell thanked Dr McCormack as that will suffice for assurance to Dr McKenna.

- **Update re COVID outbreak in the Dialysis Unit (Action 411)**

Mrs Beveridge spoke to the COVID outbreak and noted that this had been a request from Professor Wood at the previous Committee meeting. Mrs Beveridge advised that the three reports for the outbreak areas were included – QMH Renal Dialysis/ Renal OPD and VHK. The lessons learned were around PPE, social distancing and high community prevalence and high risk of these patients at that time.

Mrs Beveridge also noted an outbreak in Ward 6 which was as a result of an index case not being swabbed on admission and placed in a shared bay. The risks associated with this incident was the older estate and shared facilities. Ward 6 was also noted as being over capacity due to surge at that time.

Mrs Beveridge recognised similar themes and was mindful of all the changes in the ARHAI guidance.

Mrs Campbell thanked Mrs Beveridge and was assured that this had been robustly addressed.

- **Endocrinology Service Update (action 354)**

Dr McCormack said that this would not normally have come to the Committee and would have been filtered through the relevant channels.

- **SBAR CWT Q1 2022**

The Cancer Waiting times Q1 2022 report was noted.

- **SBAR Melanoma QPI Comparative Report 2020 – 2021**

The Melanoma QPI comparative report for 2020 – 2021 was noted.

- **SBAR NMCN Sarcoma QPI 2020 - 2021**

The Sarcoma QPI report for 2020 – 2021 was noted.

- **SBAR Renal QPI Comparative Report 2020**

The Renal QPI comparative report for 2020 was noted.

Mrs Campbell thanked the Directorate team for the comprehensive reports and not withstanding the work that has gone into them.

7.5 New Interventional Procedures

There were no new Interventional procedures submitted.

7.6 SPSO Recommendations

There were no issues from SPSO.

8 Planned Care Directorate

8.1 Directorate Governance – Speciality National Reports

There were no specialty national reports submitted.

8.2 Directorate Level Outcomes Data

- **Clinical Audit**
- **SAER Learn Summaries**

Ms Saunderson tabled LEARN summaries.
These related to:

- Controlled drugs – process was not followed when a patient came in with them in a blister pack and not in the original packing. These were also not stored correctly and then went astray 4 days later, again the process was not followed. Lesson learned and shared with staff around the vigilance with controlled drugs.
- Patient required further surgery following Orthopaedic surgery and required Riveroxaban following a Pulmonary Embolism (PE). Lesson learned is improved education and awareness of complications for patients following surgery.
- Never event with a Long anaesthetics into the patient's right eye and the service have embraced some changes and support. Development work supported by Mr Yalamarthi and Professor Wood.

8.3 Directorate Report

Incidents
There were 418 incidents reported from 1 May to 31 July 2022. 11 of these were categorised as major. Planned Care also saw a rise in the number of cardiac arrests with 6 recorded – 3 of these have been closed at the CPR review stage and 3 await outcome review. Ms Saunderson said that this strengthens the requirement that we always try and maintain CPR upskilling of training and noted that there was a backlog within the organisation due to COVID and other circumstances.

Falls
There were 61 falls across the Directorate, 5 of these falls sustained harm. LAERs have been commissioned for the two incidents which are major harm and on review there is no link to any staffing challenges in the clinical situation. There seems to

be a cluster in Wards 10 and 33 with Ward 31 following closely behind. Ms Saunderson advised that these cases are being reviewed diligently and there are no themes or contributing factors that raise cause for concern. MS Saunderson added that there is focussed work relating to Falls going on in Ward 54 with the Clinical Nurse Manager.

Medication Incidents
There were 17 medication incidents with 4 being graded as moderate. One incident has been downgraded with the possibility of another following suit.

Tissue Viability
There were two tissue viability incidents and LEARNs have been commissioned.
For the reporting period 1 May to 31 July 2022 34 tissue viability related incidents were reported as "developing on ward or caseload". Of these 34 incidents 33 patients sustained moderate harm with one patient sustaining major harm. The highest numbers were in Wards 44 and 31 with both these wards involved in the Pressure Ulcer collaborative and have Multi-Disciplinary Team work looking at the wider aspects to supplement this.

Complaints
There were 26 Stage 2 complaints closed off and 34 Stage 1 complaints closed off.
Ms Saunderson did say however, that performance falls short of the target in returning complaint responses in a timely manner.

Mrs Campbell thanked Ms Saunderson for the highlights of the Directorate report.
Mrs Campbell said that there is definitely a correlation between the staffing issues and harms across the site. Mrs Campbell was assured to hear that work that is getting taken forward in relation to improvement. Mrs Campbell wished to note as a positive the comparison over months and the trends was helpful and enabled members to see improvements or otherwise.

Mrs Campbell raised the Care Opinion post in the report to members and advised that a discussion had taken place with the Senior Charge Nurses as it was important to recognise that while we do have a degree of complaints in the system that we also receive numerous compliments and positive messages so it is good to note that.

8.4 Specialty/departmental audit & assurance data (incl. guidance)

- **Update re Robotics Assisted Surgery (Urology/Colorectal)**

Mr Yalamarthi updated the Committee on Robotics Assisted Surgery (RAS).

The following points were highlighted:
- NHS Fife has just had the first anniversary of carrying out RAS
- A total of 161 procedures have been carried out –
- Colorectal and Gynaecology are the two main specialities in which most procedures have been carried out
- The results have been very good overall
- People are learning and upskilling in the process
- Fife has been recognised as one of the three units which are performing extremely well with the Robotic implementation.
- NHS Fife is expanding in terms of the number of people who are going to be operating on the robot.

- To celebrate the robotics, there will be an event dedicated for robotics to share experiences and any date that has been collected.

Mr Yalamarthi advised that a written update will be submitted to the Committee on a bi-annual basis going forward.

Mrs Campbell asked that the data from the first year anniversary come to the November meeting a it will be helpful for the NHSF CGC to see the progress and the follow on 6 monthly. **PCD/LG**

- **HACP/DNACPR**

There was no update provided.

- **Cyclodiode Procedure Audit Report**

The Audit was noted.

- **Scottish Hip Fracture Audit & Action Plan**

Mr Yalamarthi referred to the Scottish Hip Fracture Audit and advised that the report has had an update in October 2021.

Mr Yalamarthi said it was disappointing that Fife remained an outlier. Mr Yalamarthi added that as far as the results for surgery are concerned, anticipated that these would likely be good in terms of standards of care but time to surgery is an area of concern but not a new issue. Mr Yalamarthi said that it will be kept under review and endeavour to improve on the required issues.

- **GI Unit**

Mr Yalamarthi highlighted a progress report on the GI Unit which should have been discussed at the Senior Leadership Team (SLT) meeting on Tuesday. Mr Yalamarthi was unaware of the outcome but noted that it was one year since it's implementation.

Mr Yalamarthi highlighted that all services within Planned Care have their own Governance meetings and then meet quarterly cross-specialty which has been a good learning exercise.

Mrs Campbell thanked Mr Yalamarthi for the update and noted that the GI paper was not discussed at SLT and would likely roll over to the next meeting.
Mrs Campbell asked if the Directorate teams minute or take notes at their own Clinical Governance meetings and said it may be helpful to note within the Directorate reports going forward. Mrs Campbell to discuss with Professor Wood. **LC/MW**

- **Theatre Efficiency Audit**

The audit was noted.

- **Magnetic Seed Localisation**

The presentation was noted.

8.5 New Interventional Procedures

- **Surgical Care Practitioner – Laparotomies & Surgical Staplers**

Mr Yalamarthi advised that it was a very positive development with the Surgical Care Practitioner (SCP) as gradually, over the years this staff member has been upskilled in their role and has now become the first assistant in Robotic Surgery to help with the interventions such as Laparotomies and Surgical Staplers. The Surgical Care Practitioner is going through the training process and the Directorate are keen to try and support her in this role.

Mrs Campbell thanked Mr Yalamarthi for the information and noted that it was exciting work and was good to see a change of skill set. Mrs Campbell said she was happy to support the procedures.

PCD – AOCB

Mr Yalamarthi advised that a couple of the Clinical Leads had approached him to raise awareness of an increase in complaints from patients. The main theme that was being raised was the waiting times for consultations or treatment. Mr Yalamarthi asked if there was a Board position statement that the organisation are using to respond to these complaints? Mrs Campbell responded that it was a good point to make although it wasn't really for this Committee to make a decision. Mrs Campbell added that a similar aspect was discussed in the Performance Reviews around supporting that type of information.

Mrs Dobson said that this was as a result of the discussions at the Scheduled Care Group with regards to publicly sharing the 90th centile waits. Mrs Dobson added that some thought was required on how we publicise this so that patients and members of the public who choose to are able to go online and have that insight at point of referral. There was also a point made was how to engage with the General Practitioners in terms of how they share that information with the patient at the point of referral which may help manage realistic expectations. Mrs Dobson said that she was content to look at this outwith the Committee as it could be something that is linked into the Board website. **CD**

Mrs Campbell thanked the Planned Care team for the overview provided today detailing the challenges across the whole site and also good to hear the work that is going on.

8.6 SPSO recommendations

There were no SPSO recommendations.

9 Divisional Risk Register – Active Risks

Mrs Campbell advised that the Risk Register had been discussed under agenda Item 4.1 and suggested that unless members had any new risks or completed risks to be removed then the risk register would be left as is until the new format is introduced. There were no comments.

10 Review of Terms of Reference (July 2022 version)

The updated Terms of Reference (ToR) was noted.

Mrs Campbell queried whether the ToR should include some text around the Committee being quorate as this would strengthen the ToR? The Committee agreed. Mrs Campbell to agree wording with Mrs Dobson and Professor Wood and bring back to the November meeting for approval/noting. **LC/LG**

11 Items for information only:

11.1 NHS Fife Activity Tracker

The Activity Tracker was noted.

11.2 SIGN Guidance

The SIGN Guidance was noted.

11.3 ASD CGC Workplan 2022/2023

The workplan was noted.

11.4 Infection Control Committee Minutes of 3rd August 2022 (incorporating AMT minutes of 30th June 2022)

The Infection Control Committee minutes were noted.

11.5 HAIRT Report – August 2022

The HAIRT report for August 2022 was noted.

11.6 NHS Fife CP&PAG Minute of 25th April 2022 & 20th June 2022

The NHSF CP&PAG minutes were noted.

11.7 Resuscitation Minutes of 10th May 2022

The Resuscitation Committee minutes were noted.

11.8 HTC Minutes (August update to May minutes)

As no further meetings have taken place since May 2022, an update was provided.

12 AOCB

There were no matters raised for discussion.

Mrs Campbell thanked teams for their efforts in pulling together the information for this Committee which provides the required assurance.

13 Date of Next Meeting:

Wednesday 16th November 2022 at 2.00pm via MS Teams

Area Clinical Forum

AREA CLINICAL FORUM

6 October 2022

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 6 OCTOBER 2022 AT 2PM VIA MS TEAMS

Present:
A Lawrie, Chair
J Fearn, Consultant Clinical Psychologist
R Gunn, Head of Laboratory Services *(deputising for D Galloway)*
A Mackay, Speech and Language Therapy SLT Operational Lead
S Mitchell, General Practitioner
E O'Keefe, Consultant in Dental Public Health *(part)*
J Owens, Director of Nursing
D Platt, Specsavers Optician

In Attendance:
S Fraser, Associate Director of Planning & Performance
M McGurk, Director of Finance & Strategy
H Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting, and extended a warm welcome to S Mitchell, General Practitioner who has joined the Forum to represent the GP Subcommittee and the Fife Local Medical Committee.

Apologies were received from D Galloway (Women Children & Clinical Services General Manager), B Hannan (Director of Pharmacy & Medicines), P Madill (Consultant in Public Health Medicine) and C McKenna (Medical Director).

2. Declarations of Members Interests

There were no declarations of interest from those present.

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

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The action list was updated.

There were no matters arising.

5. STRATEGY / PLANNING

5.1 Population Health and Wellbeing Strategy Progress Update

M McGurk presented on the Population Health & Wellbeing Strategy, and provided an update on progress.

The Chair commented it would be beneficial for the Forum to feedback on previous strategy work and what was achieved, to support the new strategy. M McGurk agreed to send questions and welcomed an opportunity to attend a future Forum meeting to discuss the strategy work further as it progresses.

Action: M McGurk/Board Committee Support Officer

J Owens highlighted workforce and the challenges ahead throughout the Winter period, which will impact on the implementation of the strategy. S Mitchell highlighted the challenges within General Practitioners (GPs), due to waiting lists within the hospitals. S Mitchell also noted that there is currently a lack of GPs available in local practices, particularly in the Levenmouth area, and that there is a difficulty to recruit. The Chair agreed to discuss this concern further with S Mitchell outwith the meeting.

Action: Chair

The Chair highlighted the benefits of having community connections on this Forum who can support progression of the strategy.

A MacKay noted that contact had been made from a Therapist in Australia, and one from Germany, following an advert that went out from NHS Fife and that they were both very attracted to the post, which followed their research on NHS Fife and the core values of the organisation.

5.2 Annual Delivery Plan

This item was added to the agenda.

S Fraser provided an update on the Annual Delivery Plan and advised that the plan was provided to the Board in private session at their meeting in December 2022. It was also advised the plan has now been published and S Fraser agreed to share with the Forum.

Action: S Fraser

It was reported that an update on the Annual Delivery Plan is to be provided at the end of October 2022, and will include winter actions. It was noted that this will be challenging, and a Capacity & Flow Group are involved in this work. Discussions are taking place on supporting staff and improving systems, and suggestions were welcomed from the Forum on how this can be done.

J Owens highlighted generational differences, and advised that messaging, at both local and national level, is required to reduce the pressure on the Emergency Department in hospitals. Discussion took place on pathways.

6. QUALITY / PERFORMANCE

6.1 Winter Systems Pressures Update

J Owens provided an overview on the Winter Readiness Plan, which has been published, and noted that there are no significant changes from the previous year. It was advised that the plan includes the eight priorities. The plan will be shared with the Committee.

Action: J Owens

J Owens reported that a planning event had taken place, which included discussions on the Operational Pressure Escalation Levels tool, workforce issues and wellbeing of staff. Feedback from the event will be shared with the Forum.

Action: J Owens

It was advised a weekly meeting takes place with respective Directors to discuss the pressures which are anticipated throughout the Winter on staff and services. J Owens agreed to present at the next meeting on progress of the Winter planning.

Action: J Owens

7. UPDATES FROM EXTERNAL GROUPS

7.1 Area Clinical Forum Chairs Group for Scotland Update

This item was not discussed.

8. GOVERNANCE MATTERS

8.1 Proposed Meeting Dates 2023/24

Meeting dates for 2023/24 will be sent by diary invite.

8.2 Annual Workplan

This item was not discussed.

9. Subcommittee Minutes

The Forum noted the following subcommittee minutes:

9.1 Area Pharmaceutical Committee held on Monday 29 August 2022 (unconfirmed)

10. ESCALATION OF ITEMS TO THE CLINICAL GOVERNANCE COMMITTEE

Items to escalate to the Clinical Governance Committee will be agreed by the Chair outwith the meeting.

11. ANY OTHER BUSINESS

There was no other business.

12. DATE OF NEXT MEETING

The next meeting will take place on Thursday 1 December 2022 at 2pm via MS Teams.

CANCER GOVERNANCE & STRATEGY GROUP

19 August 2022

No issues were raised for escalation to the Clinical Governance Committee.

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 14:30 on Friday 19th August 2022 via Microsoft Teams

Present:	**Designation:**
Izzy Corbain (IC)	Patient Representative
Gemma Couser (GC)	Head of Quality and Clinical Governance
Claire Dobson (CD) Acting Chair	Director of Acute Services
Susan Fraser (SF)	Associate Director of Planning & Performance
Nick Haldane (NH)	Lead Cancer GP
Ben Hannan (BH)	Director of Pharmacy & Medicines
Alistair Graham (AG)	Associate Director Digital and Information
Jennifer Leiper (JL)	Patient Representative
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Janette Owens (JO)	Director of Nursing
John Robertson (JR)	Lead Cancer Clinician - Surgery
Nicola Robertson (NR)	Associate Director of Nursing, NHS Fife
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Joanna Bowden (JB)	Consultant – Palliative Care
Catherine Jeffery Chudleigh (CJC)	Consultant in Public Health
Nicky Connor (NC)	Director Health and Social Care
Murdina MacDonald (MM)	Lead Cancer Nurse
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
In Attendance:	**Designation**
Alex Chapman (AC)	Urologist
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Megan Mowbray (MMo)	Consultant in Dematology

		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 02 June 2022 via Microsoft Teams**	
	The Unconfirmed Note of 02 June 2022 was **accepted** as an accurate record.	
3.	**Matter Arising/Action list**	
	The public health risks will be discussed under item 4.1.	

		Action
4.	**GOVERNANCE**	
4.1	**Cancer Risks**	
	GC advised there are 12 risks associated with the delivery of cancer services. GC advised 6 are graded as high and 6 are graded as moderate. GC advised since the previous meeting there has been no change. GC advised there was a discussion at the last meeting around these risks and how they are more operationally focused, and as such should sit with the Acute Cancer Services Delivery Group. GC advised there are 2 risks for consideration. GC advised they both relate to issues that have been picked up through the cervical national screening programme. GC advised one relates to the coding of no cervix exclusion, and the other relates to the misuse of suspicious malignancy function in SCCRS. GC advised both of these risks currently sit within the public health register. GC advised after reviewing these risks, it is an appropriate place for these risks to sit. GC advised there is a risk that has emerged in relation to histology wax supply issues. GC advised there is a risk that we will not be able to process samples due to the global histology wax supply issues, and this would have an impact on cancer pathology. GC advised this risk will sit more operationally. GC advised there needs to be a decision as to what risks should be tabled at this group. GC advised risks associated with the delivery of the cancer framework should be the focus and that a summary risk report will would come to this group for noting with a further summary all of the cancer risks across the organisation. The group agreed with GC's comments. JR advised a further emerging cancer risk for the group to be aware of is due to an impending shortage of Moviprep. JR advised this could have a very significant impact of endoscopy. CD advised this was raised by the Hospital Control Team and is being discussed operationally. CM asked if there was anything in the risks that does not sit within the acute services but sits with community. GC advised she does not believe there is. GC advised what they will see when the framework starts to deliver is that they probably will see more risks being added in relation to primary care and the community.	
4.2	**Acute Cancer Services Delivery Group Update**	
	CD advised the last meeting was cancelled due to the number of apologies and operational pressures.	

		Action
	CD advised the group is making good progress in terms of discussion around the operational delivery of cancer services across Fife. CD advised they have had a look at some pharmacy issues through the group. CD advised they have also discussed the delivery of SACT and how the service is currently functioning. CD advised the group is due to meet in September. BH advised they are getting into the swing of things, particularly in regard to understanding some of the day unit operational issues.	
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework & Delivery Plan**	
	KN advised they are coming up to the last leg of finalising the framework. KN advised she had sent out an email to the group asking if everyone can take the action plan and the framework to each SLT for endorsement. KN advised once this has been done, the aim is to bring it back to this group, however, as this group does not meet again until November it has been suggested an extraordinary meeting is arranged to carry out any final endorsement prior to submission at EDG in October and thereafter onto the Clinical Governance Committee in November for sign off. CM agreed to the extraordinary meeting. RH to set up meeting. KN asked if this should go to the Acute Cancer Services Delivery Group or would it be sufficient enough to go to the SLTs. CD advised it should be shared with the Acute Cancer Services Delivery Group.	**RH**
5.1.1	**Draft Cancer Framework v0.9**	
	This was shared with the group.	
5.1.2	**Management of the Cancer Delivery Plan**	
	KN advised they had agreed that the cancer delivery plan objectives will be overseen by the Cancer Leadership Team. KN advised at the last Cancer Leadership Team meeting she put through a proposal to ensure a concise approach, to inform progress and exception reporting, and provide assurance to the Cancer Governance and Strategy Group. KN advised they will use the LCAS approach: leading, critical, active contributor, and supporter. KN advised there will be an action tracker for each of the objectives. GC advised it is important that they have assurance in terms of the various work streams that are going to be delivering this. GC advised whilst the framework is going to be coming through for endorsement, a number of the work streams that have been identified have started.	
5.2	**Single Point of Contact Hub Update**	
	KN advised the pilot is launching on the 1st of September.	

		Action
	KN advised the pathway navigators have been recruited and have undergone significant training. KN advised they were fortunate to have a Macmillan training package specifically aimed at pathway navigators which has really helped with the clinical knowledge requirements of the role along with the David O'Halloran cancer for non clinicians training. KN advised they also have a skills matrix to monitor competency. KN advised the first cancer sites to be piloted are our most challenged, colorectal and urology. KN advised they will also be looking at breast or another service to pilot. KN advised they have done high level process maps and a SOP to support the team in this new service. KN advised they have developed communications for the public, staff and GPs to promote the hub which are currently just being finalised. KN advised this will include a piece for local media as a good news story. KN advised they have also developed a website for patients to access which will be available when they launch, and it will also link in with the general cancer patient facing website being developed by MM. KN advised in order to evaluate the service they have some baseline measures and the team will complete a patient enquiry questionnaire after each contact. KN advised they will also do patient questionnaires at intervals to be agreed and encourage use of Care Opinion.	
6.	**FUNDING**	
	KN shared the cancer funding streams with the group. KN advised there has been a delay to release of cancer funding streams for 2022-23. KN advised they have just had an update advising that the CWT funding is due to be released any time soon and the letters to confirm are still with John Burns. KN advised they expect our full NRAC share of £10 million (£685,996). KN advised she has no update regarding the release of the £1.5m for Acute Oncology/SACT to date. KN advised year 2 funding has been confirmed for ECDC pilot sites. KN advised discussions are still underway in relation to bids put forward for ECDC in more Boards as well as NHS Fife's bid to expand the principles of ECDC into tumour specific groups. KN advised Single Point of Contact Hub funding has been confirmed however they are still awaiting release. KN advised she has been advised that it's expected at the beginning of September.	

		Action
	KN advised Detect Cancer Early funding allocation is due to be confirmed any time now. KN advised there will be funding available to support implementation of the optimal lung pathway and NHS Fife community pharmacy have put forward a proposal for consideration – discussions are still underway. CM asked if BH knew about the community pharmacy pathway. BH advised his understanding was that it had not gone any further that what they had discussed previously in terms of bringing ECDC together as a more strategic proposal. BH advised he has not supported this going any further than it had done. KN advised it was more of an exploratory to the Scottish Government as to whether they would consider it and believed everyone was aware of this. GC advised that CM, BH, NH, Alec Murray and herself all need to meet but due to the system pressures it has not been possible to get that set up. GC advised the purpose of including it on the slide today is that it is a potential funding stream that may be in the pipeline. GC advised there has been no commitment given from Scottish Government for allocation of funding; however, they are keen to hear a bid from us. CM advised he has not seen any papers in relation to bids towards ECDC. CM advised they had a lot of conversation about what EDG's anticipation of this project was and before it was expanded it would go through EDG and CGC. CM asked if a proposal has been put forward to the Scottish Government for more funding. GC advised her understanding through discussion with Murray and the planned care team is that there has been a bid developed, and there has been discussion with the Scottish Government, although she has seen no formality come through. GC advised this highlights the importance of the governance, and that they need to make sure it is in place. GC advised the discussion that she had with Murray was the requirement for it to be going through SLT and then onto EDG. GC advised she will pick this one up offline. GC advised with funding streams like SPOCH where there is a commitment to give it on a recurring basis but there is still this annual allocation and the anxiety it creates. GC advised she is unsure if there is a way to feed this back to Scottish Government colleagues. KN advised this was brought up at the National Cancer Delivery Group a few weeks ago. JL advised it would be helpful to see these funding streams against the current funding that they have. CM advised this would be tricky as cancer funding does not sit separately to other service funding as cancer service delivery sits within departments that also do other things, it would be hard to see what would just be for cancer. CM advised BH can tell how much money they spend on cancer drugs. CM advised we can bring this to the next meeting and can bring something about the trajectory that it is going in. BH advised himself and CD can take a walkthrough in terms of the challenges with the increase in spend in cancer therapy. CD advised they need to look what the cancer spend is within their larger budgets, and	**GC/CM/ BH/NH** **BH/CD**

		Action
	perhaps an indication about how much activity that they drive through some of the programmes relating to cancer.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times**	
7.1.1	**Quarter 1 2022**	
	KN advised the performance continues to deteriorate for the 62 day standard across Scotland achieving 76.9% for Quarter 1 2022, and Fife achieved 78.4% for this period which is above the Scottish average. KN advised the breaches ranged from 1 day over to 97 days over the 62 days and 28% of them breached by 10 days or less. KN advised she has looked at the draft figures for Q2 2022. KN advised no Boards have met the standard and Fife have achieved 85.1% for 62 day (2nd best performer across Scotland next to the Borders) and 97.5% for 31 days. KN advised Scotland continues to achieve the 31 day standard with 96.3%. KN advised Fife achieved 100%. KN advised going into quarter 2 they expect to see the impact of the removal of the non standard technology waiting times adjustment for robotic prostatectomy. KN advised initially this won't affect us as we currently don't perform this in Fife, however, as this service moves to Fife we may see an impact on our performance if waits exceed 31 days from decision to treat. KN advised a further impact on our performance will seen with the eventual removal of the waiting times adjustment that we can currently apply for self isolation prior to surgery. KN advised one of the key objectives of the effective cancer management framework is to ensure effective breach analysis. KN advised a national 'Once for Scotland' is to be taken and a SLWG has been set up to agree how we can manage and learn from breaches. KN advised the first meeting is at the beginning of September.	
7.2	**Quality Performance Indicators**	
7.2.1	**Melanoma 2020-21**	
	MMo went through the papers that were shared with the group. Case ascertainment for NHS Fife is 87%. NHS Fife met 6 of the 14 (including sub-QPIs) QPIs for melanoma. QPIs not met: • QPI3: The target was not met showing a shortfall of 1.7% (4 cases). For these cases, 1 patient declined further (definitive) treatment (stage IIA), 1 case was diagnosed by WLE (stage IA), 1 case had no further treatment due to co-morbidities (stage IA), and 1 patient experience rapid progression and died, with excision only performed (stage IV).	

		Action
	• QPI6: The target was not met showing a shortfall of 1.9% (4 cases). For 1 of these cases WLE was not performed due to disease progression, 1 case identified metastatic disease by CT and WLE was no longer appropriate, 1 patient had significant co-morbidities, and 1 patient declined further treatment. • QPI7(i): The target was not met showing a shortfall of 33.3% (18 cases). For these 18 cases, 4 were patient induced delays, 2 had no WLE performed, 2 experienced both admin errors by both Pathology and Dermatology and issues with plastics capacity, 2 experienced a delay in Dermatology referral to plastics, 2 had issues with Plastics capacity, 2 patients were complex cases, with the first requiring a pathology 2nd opinion and the second with co-morbidities causing surgical delay, 1 case experienced both an issue with Plastics capacity and patient induced delay, 1 case was a plastics delay in listing for MDM, 1 delay in referral to MDM and issues with Plastics capacity, and 1 case had a Pathology delay. • QPI7(ii): The target was not met showing a shortfall of 28.3% (4 cases). For 3 cases patients had no WLE performed, and for 1 case there was a patient induced delay. • QPI9: The target was not met showing a shortfall of 52.1% (8 cases). For these 8 cases, 3 patients were upstaged following a positive SLNB, for 3 cases no reason for the delay was identified, 1 patient had initial CT request rejected as an eGFR was required, and 1 patient had an usual pathway with CT prior to diagnosis. • QPI10: The target was not met showing a shortfall of 60.0% (3 cases). For these 3 cases, 2 patients were treated with Best Supportive Care due to co-morbidities, and 1 patient had rapid progression of disease and died shortly after presentation. • QPI12: The target was not met showing a shortfall of 16.5% (17 cases). For these 17 cases, 9 patients had no excision biopsy prior to WLE, 7 patients had a diagnostic excision biopsy but margin was not recorded, and 1 case was an incidental finding of a 5mm excision for dysplastic naevus (patient choice for removal) • Clinical Trials: Numbers of patients being consented for melanoma trials are small because it's currently a small subset of metastatic patients that are being offered trials. There were no Board specific actions identified for NHS Fife.	
7.2.2	**Renal 2020**	
	AC went through the papers that were shared with the group. Case Ascertainment for NHS Fife is 108.1% In NHS Fife 67 patients (61 previous cohort) were diagnosed with renal cancer. NHS Fife met 8 of the 18 QPIs for Renal cancer (including sub-QPIs). 5 QPIs had no patients applicable.	

		Action
	QPIs Not Met: • QPI 1: Radiological Diagnosis with cross sectional imaging. A shortfall of 0.6% (2 cases) – 1 patient had CT without contrast and 1 patient did not have a CT chest. • QPI 3: Clinical staging – TNM. A shortfall of 14.4% (11 cases) - 4 had no TNM staging documented. 7 had incomplete TNM documented. • QPI 10: Prognostic scoring for metastatic disease. A shortfall of 43.3% (8 cases) No prognostic scores recorded. • QPI 11: Leibovich score. Not used as a risk stratification tool in NHS Fife. Therefore, performance for this QPI is 0%. • QPI 14: Clinical Trial QPI– 4.8% There were three actions identified for NHS Fife: • Suggest a new section in the MDM list with TNM prompt required to ensure that TNM is recorded at MDM. • Oncology colleagues to be reminded of this QPI requirement and prognostic scoring should be noted at MDM. • NHS Fife to explore why NHS Fife are not involved in the tissue banking studies currently available.	
7.2.3	**Sarcoma 2020-21**	
	CM advised this is here for information only. A summary of the sarcoma QPI performance for the 2020/21 audit period is presented below, with a more detailed analysis of the results set out in the main report. Data are analysed by location of diagnosis or treatment and illustrate NHS Board or treatment-centre performance against each target and overall national performance for each performance indicator. It is evident that many of the QPI targets set have been challenging for centres to achieve and several areas for improvement have been highlighted. It should however be noted that given the rarity of sarcoma, numbers included within the measurement of most indicators are small and therefore percentages should be compared with caution. Data capture has improved over the six-year period which provides a good foundation from which to measure service improvement. All regions met QPI targets for primary flap reconstruction, multi agent chemotherapy for Ewing's sarcoma and 30-day mortality following curative treatment 299 patients were diagnosed with sarcoma in 2020-2021. 80.2% of cases diagnosed in Year 7 were in patients' ≥ 50 years. 54.8% were male and 45.2% were female. Scotland met 11 (+1 n/a) of the 20 QPIs (including sub-QPIs). Reasons for not meeting the QPIs are documented within the report.	

		Action
	There was 1 action identified across Scotland: • QPI 3: All centres to ensure recording of TNM for all sarcomas The NMCN will actively take forward national actions identified, and NHS Boards are asked to develop local Action/Improvement Plans in response to the findings presented in the report.	
8.	**SCAN UPDATE**	
8.1	SCAN Update	
	GC advised Nicola McCloskey-Sellar has been appointed as the SCAN Network Manager, taking up post on 26 September 2022. GC advised NHS Fife has written back to NHS Lothian confirming NHS Fife's support of the Initial Agreement for reprovision of the Edinburgh Cancer Centre. GC advised within that they have asked for reassurance around ongoing regional discussions in terms of workforce and the service models for the regional cancer centre. GC advised they have also given their support for further exploration of the decentralised radiotherapy model, asking for some outline in terms of how that process would be managed.	
9.	**LINKED COMMITTEE MINUTES**	
9.1	**Cancer Managers' Forum (29/04/2022 & 22/07/2022)**	
	This was noted by the group.	
9.2	**Cancer Leadership Team (17/05/2022)**	
	This was noted by the group.	
9.3	**Early Cancer Diagnosis Centres Oversight Group (30/06/2022)**	
	This was noted by the group.	
9.4	**Cancer Delivery Board (03/08/2022)**	
	This was noted by the group.	
10.	**Items to Note**	
	No items to note	
11.	**ISSUES TO BE ESCALATED**	
	No issues to be escalated	
12.	**ANY OTHER BUSINESS**	
	None	

		Action
13.	**Date of Next Meeting:**	
	An extraordinary meeting will be arranged, date TBC. The next meeting would be on Friday 04th November 2022 at 2.00pm via Microsoft Teams.	

NHS Fife Clinical Governance Oversight Group

NHS Fife Clinical Governance Oversight Group

16 August 2022

At the 16th of August NHS Fife Clinical Governance Oversight Group a number of issues were noted for escalation as follows:

- Clinical Governance framework
- A report on the deaths of children and young people

Both issues noted above are on the agenda for the November meeting for the Clinical Governance Committee.

Date: 16/08/2022
Enquiries to: Dorothy Gibson
Telephone Ext: Microsoft Teams

CONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 16 AUGUST 2022 AT 10.00 via MICROSOFT TEAMS

Attendees

Lynn Barker – (LB)	Associate Director of Nursing, of Health and Social Care Partnership
Sue Blair (SB)	Consultant in Occupational Medicine
Lynn Campbell – (LC)	Associate Director of Nursing, Acute Services Division
Pauline Cumming (PC)	Risk Manager
Claire Fulton - (CF)	Lead for Adverse Events
Catherine Gilvear – (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Geraldine Smith – (GS)	Lead Pharmacist Medical Governance
Aileen Lawrie – (AL)	Associate Director of Midwifery
Siobhan Mcilroy- (SM)	Head of Patient Experience
Sally O'Brien - (SO'B)	Head of Nursing
Dr Chris McKenna - (CMCK) (Chair)	Medical Director
Elizabeth Muir - (EM)	Clinical Effectiveness Manager
Amanda Wong – (AW)	Director of Allied Health Professionals

In attendance

Dorothy Gibson- DG	Clinical Governance Administrator

Apologies

Gemma Couser – (GC)	Associate Director of Quality & Clinical Governance
Benjamin Hannan – (BH)	Director of Pharmacy & Medicines
Dr Helen Hellewell – (HH)	Associate Medical Director
Nicola Robertson – (NR)	Assistant Director of Nursing, Corporate Division
Janette Owens – (JO)	Director of Nursing
Dr John Morrice – (JM)	Consultant Paediatrician
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 14th June 2022**	
	The Group confirmed that the note from the meeting held on the 14th of June 2022, was a true reflection of what was discussed.	
3	**Matters Arising/Action List**	
	• Item 5.2 Draft Clinical and Care Governance Framework will be discussed as an agenda item • Item 6.2 HSCP Quality Matter Assurance Group Report following discussion this will now be removed as an agenda item and can be closed.	

	• Item 7.1 carried forward CF/SM to discuss.	CF/SM

4	**GOVERNANCE**	
4.1	**NHS Fife Clinical Policy & Procedure Update**	
	At the June meeting the group approved one new Fife Wide Procedure. **FWP-ECRS-01 - NHS Fife Wide Procedure for all Emergency Calls received through Switchboard** • It was identified through the NHS Fife Resuscitation Committee that there was no assurance and no quality checks for people either being added on to pagers or removed from pagers for 2222 calls or emergency calls. • **Outstanding Policies and Procedures** • There is one policy and two procedures past their review date. **Fife Wide Policy** IC-02 - NHS Fife Infection Control Policy for the Risk Assessment for Transmissible Spongiform Encephalopathy Agents including CJD and vCJD (31/08/2021). The Infection Control Manager advised that the policy stays out of date as it is currently not fit for purpose. The policy should be finalised for the August meeting of the group. • **Acute Services Division** ASD-POPI-01 Acute Services Division Pre-operative Patient Identification: the identification and preparation of patients undergoing operative and invasive procedures (18/02/2022). ASD-BP-01 Boarding Procedure for Patients within the Acute Services Division (31/03/2022). • **97 %** of all clinical policies and procedures are current and in date.	
4.2	**NHS Fife Activity Tracker (EM)**	
	Reports and Publications – For Information **When a child dies; the 2022 report shows the learning's from bereaved families and Carers.** The report makes eight recommendations to NHS boards, local authorities, public protection committees, third sector organisations and the National Hub to help improve the review process for families and carers. Recommendations emphasise the importance of conducting reviews into the deaths of children and young people in a manner that is flexible, sensitive and family-orientated. A key contact will be identified for the family before, during and after the review	

process; it is also recommended that in order to improve the review process, systems should be developed to monitor the quality of reviews to ensure that the interests of families and carers are represented throughout.

Infection Prevention and control Standards For Health and adult social care settings

The 2022 Standards report details our main activities and gives an update on:

- Organisations to quality assure their IPC practise and approaches.
- The IPC principles set out in the National Infection Prevention and Control Manual.

These standards will underpin Healthcare Improvement Scotland's programme of inspection of the safety and cleanliness in acute and community hospitals.

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

Scottish Health Technology Group

The 2022 Complex endovascular aneurysm repair (C-EVAR) report is associated with a limited and low-quality evidence base.

The advantages of C-EVAR remain unclear compared with:

- open surgical repair (OSR), in people for whom OSR is a suitable intervention.
- non-surgical management, in people for whom OSR is not suitable intervention.

C-EVAR of complex abdominal aortic aneurysms (AAAs) or thoracoabdominal aneurysms (TAAAs) offers an alternative to OSR and is often considered for patients with perceived moderate/high operative risk.

The 2022 report, Advice for NHS Scotland - KardiaMobile® for detecting atria fibrillation

This report details our main activities and gives an update on:

All patients for whom the use of C-EVAR is being considered should have their case discussed as part of a multidisciplinary team. The consequences of C-EVAR, including uncertainties around re-intervention and survival, should be discussed with each patient as part of making a treatment decision.

Single-lead KaridaMobile® is recommended as an option for detecting atria fibrillation (AF) for people with suspected paroxysmal AF, who present with systems such as palpitations and are referred for ambulatory electrocardiogram (ECG) monitoring by a clinician.

The Scottish Health Technology Group (SHTG) recommendation is based on guidance produced by the National Institute for Health and Care Excellence (NICE) in 2022.

Technologies that allow ambulatory monitoring of AF are rapidly evolving.

	While these advancements in the technology are welcome, they have led to variation in practice and a need to understand the relative value of AF monitoring technologies. SHTG's advice will inform the use of KardiaMobile® in Scotland. CMcK advised that this information has been sent in from Health Improvement Scotland (HIS), and there is Governance of the device support by HIS. However, it is unclear what the NHS Fife Governance route followed is, to implement the use of Kardia. The expected route would have been through the NHS Fife Acute Services Division Committee (ASDC), and that has not been followed. CMcK advised that he has written to Cardiology and Shirley-Anne Savage to request the adoption of use in Kardia in NHS Fife and for it to be sent through the (ASDC).	
4.3	**NHS Fife Clinical Effectiveness Register Update Report (EM)**	
	In the last 6 months there have been 51 projects registered; these are both local and National. The registered projects have decreased slightly from the last 6 months where there was 64 projects registered. Data on registered projects can be extracted and will be used to inform directorates/divisions of the work that is being carried out in their areas which should lead to improved reporting and governance. Projects registered are given to the Acute Services Directorates (ASD) on a quarterly basis for their Clinical Governance meetings. The clinical effectiveness register is regularly promoted on the intranet to encourage staff to register audits, improvement work and service evaluations. Within the Clinical Effectiveness Team, work is ongoing to ensure that reports are submitted for completed projects to groups and committees. PC would it be possible to receive a breakdown of the projects i.e. subject matter and topics, to enable a connection between the strategic priorities. EM advised that this information is available and this could be added as an appendix to the report if the Directorates are in agreement for the information to be sent out to them.	EM
4.4	**Draft Annual Assurance Statement (CMcK)**	
	Members of the Group approved the Draft Annual Assurance Statement and therefore; this will be sent to the next NHS Fife Clinical Governance Committee for approval.	
5	**STRATEGY/PLANNING**	
5.1	Draft Clinical and Care Governance Framework **(GC)**	
	CMcK to follow up with GC and for the document to be circulated to the group for remote feedback.	CMcK/GC
5.2	National Hub for Learning and Reviewing of Deaths of Children and Young People Update **(CF)**	
	There have been 21 deaths recorded since the go live review process of 1st October 2021. Two of the reviews have been completed and we have ongoing 6 joint Board reviews.	

	Recently our Child & Young Persons Death Review Coordinator recently Lesley Cunningham took up post. The focus will be to set up meetings with other Boards and to look at joint Board cases, and to firm up the process that is currently in place. To look at the Bereavement support that is in place for families i.e. information leaflets and how to engage families and their carer's with the process. A report will be provided at the next NHS Fife Clinical Governance Oversight Group meeting for review before going to the NHS Fife Clinical Governance Committee in November. CMcK asked if we have a breakdown of where the 21 deaths occurred. CF gave an overview of the breakdown of cases: • 6 Cases In hospital, NHS Fife - within women's and children's directorate • 3 Cases In hospital, NHS Fife - any other location • 9 Cases In hospital - other board • 1 Case Deaths in community – with NHS Fife remit • 2 Cases Deaths in community – within external partnership agencies remit	**CF**
6	**QUALITY/PERFORMANCE**	
6.1	NHS Fife Integrated Performance & Quality Report May 2022 **(CMcK)**	
	This report will be going to the next NHS Fife Clinical Governance Committee for approval. CMcK raised that the report highlights that the number of stage 2 complaints aren't improving. SM (new in post).highlighted that there were 80 complaints waiting to be drafted with the Patient Relations Team in May 2022. There are 47% of complaints waiting to be approved and 40% waiting for statements. CMcK requested that the report needs to be closely monitored due to the increase in the number of stage 2 complaints.	
6.2	HSCP Quality Matters Report April 2022 **(LB)**	
	CMcK asked LB why the report comes to this group, as we don't have one for the Acute. LB responded that this perhaps has been a historical item and is happy for this to be removed as an agenda item.	
6.3	Quality & Safety Board Assurance Framework **(BAF) (PC)**	
	The (BAF) will be going to the NHS Fife Clinical Governance Committee for the final time in September before it is replaced with the Corporate Risk Register. PC commented that there is a paper going to the next Executive Directors Group (EDG) meeting, proposing the work that has been done to identify potential Corporate Risks for inclusion in the Corporate Risk Register. This will feed into each of the Clinical Governance Committees in September 2022. An update will be available for discussion at the October meeting of the NHS Fife Clinical Governance Oversight Group.	

	CMcK - Corporate Risk's relating to Corporate Quality & Safety will come to the next meeting of the NHS Fife Clinical Governance Oversight Group in the first instance. PC advised that the Risks would be categorised and it has been decided that they will be mapped into the 4 strategic priorities.	

7	**Adverse Events & Duty of Candour Status Update (CF)**	
7.1	Flash Card	
	The Flash Card shows the events over the last 2 months. There is not a large amount of change in the numbers reported. There are not any changes in the sub – categories or the top categories, these are fairly consistent. Data that was extracted from the IPQR noted that there has been an increase in trend of cardiac arrests, 14 for May, 11 for June 2022. Usually the average over the 10 months preceding was 5.5 per month. Therefore, there is a significant increase in May and June 2022. In July 2022 there have been 8 cases, and at the time of the meeting there was one reported cardiac arrest in August 2022. The data has been provided showing the cases by location as the cases are not in Cardiology or areas where you would expect to see an increase in cardiac arrests. The chart shows all the months over the year. Cardiology consistently only have 1 or 2 cases, and Intensive Care have 3 in May and 2 in June 2022 where there has been an increase. This is a similar picture in AU1 and A&E where there would only normally be 1 case or none in a month. All the cases have been reviewed at the CPR SBAR Review Group meetings. Gavin Simpson has asked that a few points to be brought for consideration. • The observations on time have been dropping as a percentage over the last few months and it is thought that a contributory factor could be staffing. • The average number of patients in care has not hugely increased however, the burden of sickness overall has increased. Duty of Candour (DOC) there has been 23 activations so far in year 4. There will be a report due at the end of this year. On preparation of the interim data it was noted that there had been 1 activation of DOC within Community Care Services, from a cluster review of health care associated infections that involved 3 individual cases all with similar outcome. It was discussed that these should have been 3 separate activations of the duty; this will be fedback to the service.	
7.2	Proposal to manage back log of LAER's	
	There has been discussion about clustering the number of LAER's and how these would be made into categories i.e. into falls or medication incidents and to look at them as a cluster of cases to progress these instead of looking at them all with individual cases.	

	A more formalised approach is proposed to produce a paper for the next NHS Fife Clinical Governance Committee for agreement.	

7.3	KPI's	
	The KPI chart is attached; there is not a lot of variation within this month's KPI's The SBAR's received across the months of May, June and July 2022 show there has been a delay in SBAR's received and not received. Currently there are 44% of SBAR's not received at the end of July 2022. There are 11 outstanding SBAR's at the end of July 2022, 5 of which were for Cardiac arrests, and the August 2022 mid way update is that we have 12 overdue SBAR's; 5 of them being cardiac arrests. Discussion took place regarding whether cardiac arrests aren't always major; only 2 cardiac arrests within the last year have been escalated to an SAER. There have not been many in major terms of harm from the cardiac arrest itself; those that have been received from the SBAR show a review of care, from the nursing and medical staff that have been involved. This will go forward to be reviewed at the meeting. Perhaps it is setting an unrealistic target where an SBAR should be received within 5 days. For Cardiac arrests SBAR's more time maybe needed. SAER completion; this is the National picture and was presented at the Adverse Events network last month. In January 2020 to April 2022 only 3.4% of SAER's were completed within 90 days across Scotland, 50% were at 408 days, there was a significant number at the last data point, where there were still 700 SAER's showing as open. The NHS Fife completion times, for the same time period, is on average 144 days for LAER's and 190 days for SAER.	
8	**Adverse Events Improvement Work (CF)** CF gave an update on the Adverse Events improvement plan and presented key pieces of work for consideration and progression by the group. This verbal update was supported by an SBAR and appendices which were circulated prior to the meeting. It was agreed that the information would be sent to all Associate Directors by CF with a request for comments. The updated templates and tools would then come back to this group for approval.	ALL/CF
	NOTE: All Appendices were circulated with the papers to the Group in relation to the topics below for agenda items 8.1, 8.2 & 8.3.	
8.1	Trigger List – Appendix 1	
	Trigger list, with consultation of key stakeholders is updated as part of the policy review. A decision making tool in addition to the trigger list is used to support decision making at all levels on the required level of review with a focus on opportunities for learning.	
8.2	SBAR Process Update – Appendix 2	
	An additional layer is added to the SBAR process that sees a sharing of responsibility for decision making across the senior leadership team of the	

	required level of review for adverse events. The trigger list and decision making tool will be readily available to support this process. A quarterly audit of random samples of SBAR decisions will provide assurance of adherence to policy and guideline. Appendix 3 provides suggested new process for discussion.	
8.3	Templates (SAER, LAER & CCR) Appendix 3	
	New templates are proposed for SAER's; LAER's and in addition a new Complex Care Review (CCR). The proposal for the CCR is to provide a standardised template for moderate harm events, as dictated by the trigger list that require a robust and evidenced review with the opportunity for escalation. CCR templates can be adapted to meet the review requirements for specific events e.g. catheter relater e-coli infection. It is proposed that the current SBAR paper process is moved to an electronic process where information and decisions are recorded within the Datix record.	
9	**PATIENT EXPERIENCE**	
9.1	General Update **(NR)**	
	SM provided an update in the absence of NR. Datix is currently being reviewed and the current systems. Extra fields have been added into Datix; to enable us to extract data. Weekly reports will be reintroduced and sent out to the services as this information was beneficial to them. There will be work to be done in Datix e.g. what other fields can be put in to provide extra information; i.e. to let us know how long it has taken for every step in the system and processes to get a complaint through the handling process. Literature reviews are taking place regarding themes and grading; as it takes longer to do a more complex complaint. Currently there is no system in place to enable grading of the easy, moderate and complex complaints. Further process mapping will be done within the complaint's department, to enable us to streamline our processes. Feedback is being sought from patients and families about the complaint process. A feedback questionnaire has been introduced. Unfortunately it was sent out in a PDF format. This was not fit for purpose; it has now been issued as a Word document. Only one response has been received to date providing feedback. SM will be reviewing the "opt" in system and will progress and provide feedback. SM has in contacted E-Health to find out if there any other digital systems that could be used for this process. Patient Relations is being rebranded and will be renamed as the Patient Experience Team. SM to provide a report (as a flash card) for the next NHS Fife Clinical Governance Oversight Group meeting.	SM
10	**LINKED COMMITTEE MINUTES**	

10.1	NHS Fife Clinical Policy & Procedure Coordination & Authorisation Group 20th June 2022.	
	The minutes of the meeting were noted by the Group.	
10.2	NHS Fife Resuscitation Committee 2022 10th May 2022.	
	The minutes of the meeting were noted by the Group.	
11	**ITEMS TO NOTE**	
12	**ISSUES TO BE ESCALATED**	
	CMcK will speak with GC for an update regarding the Clinical Governance Framework. CMcK - a report on The Deaths of Children and Young People will go to the NHS Fife Clinical Governance Committee in November 2022. It was agreed that once all of the Adverse Event processes have been reviewed they will go to the NHS Fife Clinical Governance Committee.	CMcK CF
13	**ANY OTHER BUSINESS**	
	No other Competent Business.	
	Date of Next Meeting 6th December 2022 10.00 via Microsoft Teams	

Clinical Governance Committee

DIGITAL AND INFORMATION BOARD
(Meeting on 18 October 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON TUESDDAY 18TH OCTOBER 2022,0900, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Associate Director, Digital & Information
Rachel Heagney	Head of Improvement, Transformation & PMO on behalf of Director Health & Social Care
Margo McGurk	Director of Finance & Strategy
Joy Tomlinson	Director of Public Health
Duncan Wilson	Lead Pharmacist on behalf of Director of Pharmacy & Medicines

In Attendance:	
Andy Brown	Principal Auditor
Lynn Barker	Associate Director of Nursing
Eileen Duncan	Directorate Solutions Manager H&SCP
Marie Richmond	Head of Digital Strategic Delivery
Claire Neal	(Minute) PA to Associate Director, Digital & Information
Amanda Wong	Associate Director, AHPs
Allan Young	Head of Digital Operations, Digital & Information
Apologies:	
Claire Dobson	Director of Acute Services
Janette Keenan	Director of Nursing
Sharon Mullan	General Practitioner
Caroline Somerville	eESS Support Teams, (on behalf of Partnership Representative)
Margaret Guthrie	Head of Information Governance & Security / DPO
Miriam Watts	General Manager, Emergency Care
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
John Chalmers	Clinical Lead, Digital & Information
Helen Hellewell	Associate Medical Director
Jillian Torrens	Senior Manager, Mental Health & Learning Disabilities Service

1	**WELCOME AND APOLOGIES**	
	Dr McKenna welcomed everyone to the meeting. Apologies were noted to the Board.	
2	**MINUTE & ACTIONS OF MEETING HELD – 28th July 2022**	
	Minutes were reviewed and agreed. Updates were provided for completed action.	
3	**MATTERS ARISING**	
	3.1 Electronic Patient Record (EPR) Governance M Richmond introduced item and provided background to paper noting the Programmes team have spent some time aligning their areas of work, one of which is Electronic Patient Record (EPR) and the paper outlines what we are trying to achieve with this programme. We are seeking comment and approval to formulate a EPR Steering Group who will make these decisions. There are three areas of focus: • The paper record which is currently held for the patient. • Prevention of paper being added to this record. • Our Digital Front Door.	

	In the structure there is a particular group looks at governance of digital Forms. While a successful project, the work with Morse has created a large number of forms that could be rationalised through review and may reduce the number of forms. A governance group would be established to govern digital forms across all systems. Clinical engagement is key and studies have been undertaken and found that leading EPR development clinically is a key factor in achieve success. Dr McKenna queried if this has been presented to SLTs as this would be good to include H&SCP and Acute. M Richmond noted no, but will present this to SLTs as keen to have input from Nurse AHP's etc. A discussion was undertaken on the membership for this group, it was noted this may sit well with the Deputy Medical Director, and Associate Director of Nursing, Chief Registrars, and Junior Doctors would also be helpful to be included with their knowledge. A Graham noted that a number of groups already exist but are in isolation of each other. Reviewing the overall system would be a great benefit to the Clinician. It would also take some responsibility and understands the impact of methodology It was decided for this to be taken to SLTs from a possible operational point and they can discuss who to chair and the right representation. Further discussion to be taken offline, M Richmond to contact Morwenna for possible trainees. **Action** - MR to contact Morwenna. M Richmond noted a conversation has taken place with J Keenan and the Forms Review Group. **Support** was noted for this paper but mindful of time constraints and the current pressures. To be presented to SLT **Action** - MR to present to SLT	**MR** **MR**
	3.2 Digital Incident Management Improvements A Young delivered a presentation and provided a brief background to paper. There have been a number of incidents over the last few years both internally and externally which have required a response from Digital. Due to these incidents, we have created an Architecture and Resilience Team and they focus on business continuity. Improvements and benefits to this are: • Efficient and available incident response processes and procedures • Looking to create a focused responder team, this will allow defined roles. Ability to check and this will align with NIS. • Improve ability to detect, diagnose, mitigate, resolve, and prevent future incidents Progress made so far: • Continuous improvement. • We have moved our categories and aligned with NIS. A Young provided a brief background to the risk levels. • Co-ordinated response playbooks for different scenarios. As we progress these will be updated, and lessons learned. Actions to be undertaken:	

	• We need to be consistent with managed recording. Within large incidents these are dealt with well, action lists are created and followed through till the end, but we also need to follow this with smaller incidents. • Tabletop exercises are being created through the organisation. • Labs and Radiology are going to be included so they are following the same process. J Tomlinson noted the Resilience Forum has been working and testing has been undertaken and has been successful. Incident with Adastra the Scottish Government were requesting a "sitrep", this was tested, and information was provided back and successful. A Graham noted a considerable amount of work has been undertaken to achieve this. This has been ongoing for 20 months and we are in a very strong position, and we can evidence this to EDG. C McKenna thanked A Young and noted their hard work was visible and work ongoing that is required. **Assurance** was noted from this paper and was provided for information only. No more 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 currently 42 risks. This is lower than the previous report. A brief background was provided to the reduction in risks. • There are a total of 12 High risks, 9 of these have now reduced and 3 risks with a accept / monitor level, e.g., 224, 225 and 1738. • There are 20 moderate risks, with 7 accept / monitor e.g., 219, 234 and 1266. • There are 10 low risks, with 2 accept / monitor e.g., 534 and 1178. • Risks 1500 and 885 these will remain from the Board Assurance Framework A Graham provided feedback to the risk profile graphic and advised that risk 1738 was in the high category but has now decreased to a low risk. We will continue to highlight any risks relating to Cyber and Security as there are some legacy systems and these carry more risk. Risk 2192 is associated with ITIL, this will take time to implement due to the scale, work is continuing, and it is hoped this will be completed by Oct 2023. M McGurk thanked for this report and for the detailed information contained. They are going to use the visuals into the Corporate Risk Register. No more 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:	

	• **EOL Servers**. 2003 - Good progress has been made removing 5 high risk servers with 2 remaining. Work is ongoing with these as they are legacy systems. • **EOL Server 2008** - this is steadily being reduced as we moved through the GP estate and clinical services. • **Win 10**, we are nearly complete, last few are with Pharmacy and work is continuing to review. • **Account Provisioning** is rated below our target. This is due to resource demands. This has been reviewed and recruiting is now underway to have designated focus on this so hopeful this will improve. • **Cyber Security Score** remains consistently under 30. NHS Fife are one of the top boards. A Young noted overall there are no concerns to report, majority of work is within SLA. A Graham noted the call volume for switchboard, there is improvement work ongoing that will hopefully improve. J Tomlinson queried the SMR01's as this is red. A Graham advised this is due to resourcing issue, some members of the team have left but these posts have now been filled, but training takes time for clinical coding. C McKenna gave thanks to the hard work, seeing majority of greens is a testament to this. No more comments were raised. **Assurance** was taken from updated report.	
6	**Strategy & Programmes/Projects**	
	6.1 Programme & Projects Update Marie introduced paper and advised since the last meeting in July, Strategy and Programmes have spent some time aligning their portfolio and creating a new team structure which will allow for more focused approach. M Richmond provided a brief update to this structure. Despite continued challenges with recruitment a new Regional Programme Manager will commence on 31st October which will be a great addition to the team. M Richmond provided an update to this some of the items within the project update. A brief update is noted below: • **CHI** – There are current challenges with Child Health, this is due to the national delivery plan and the solution specifications. Work is continuing to resolve this. May use the VMT for the vaccination programme or ATOS. • **eRostering** – will be rolled out to 9 areas within the next 2 months. Issues have been identified but these have been raised with National Team and Allocate, and they are actively working on to resolve. Concerns have been raised regarding the deployment model used by Allocate, but this is being work through. It is hoped this will be delivered by Oct 24 to the whole organisation. D&I are one of the first departments to use. There have been some issues and concerns raised but is going well. Discussions are continuing regarding the funding for Acute and H&SCP. • **M365** – Work is continuing to move through phase 2. We will look to seek assistance from a SharePoint Consultant for phase 3.	

	• **EPR** – Work ongoing, awaiting recruitment for the Programme Manager. • **ACRT / PIR** – Now commencing and the is hoped this will be in 9 areas by Dec 22. Currently working with C Dobson. • **Quebuster** – a new call handling solution due to be implemented by 26th October. This will hopefully remove some the challenges within Switchboard. • **HEPMA** – Progressing contract with new suppliers and this is awaiting signoff. From the above highlights feedback was received: Discussion was undertaken regarding the amount of work being undertaken at present and concerns were raised and queried if the number of projects is actually achievable. This is very ambitious on what we are trying to deliver, and do we need to prioritise? M McGurk also shared their concerns on the priority of all these projects eRostering, as they believe this doesn't interact with SSTS and this requires double entry onto both systems. Understand this being lead nationally but a system that doesn't work for a Health Board. M Richmond provided feedback to this comment and noted, Allocate presented with a delivery methodology but this didn't suit so we have had more work than expected on the build but are working with Allocate to solve this. This project is moving at pace but not at the pace we had hoped. M McGurk advised the financial position will be brought to EDG on Thursday and with these discussions it may be necessary to further prioritise projects and what can continue. A query was raised regarding start of ACRT / PIR, M Richmond noted this had been on hold, but through the national work supporting Planned Care and the mandate from NHS Fife's integrated planned care group this implementation work was progressing. After lengthy discussions regarding the amount of projects current being undertaken it was noted this should be reviewed, prioritise projects and updates provided. No more comments were raised. Paper is provided only for update to current projects.	
	6.2 Delivery Plan A Graham delivered a presentation and provided a brief background to paper noting this will take to conclusion of the digital strategy 23-24. Due to issues with resource and the winter pressures it was decided to delay the Trackcare User Interface upgrade till 2023. This will also allow us to concentrate on LIMS replacement. Although the delivery plan and projects were discussed in detail in the above item this is for information and noting this paper is for assurance to Board, we are on track. No comments were raised.	

	6.3 Strategy Update – Digital First A presentation was delivered by A Graham, noting this paper has been discussed at other meetings brought to Board as an update and for information on work ongoing. As we move from the Digital Strategy to the Digital enablement of the Population Health and Wellbeing Strategy, we can use supporting digital tools, activities, and processes internally and externally to engage with population. We are implementing a number of system that would fall under the category of "digital front door" A Graham gave feedback to each slide noting some of the below updates: • Challenges we face in Fife regarding the availability of resource and how we retain this service. • Increase in demand in services, how we deal with this. • Implementation of IT solutions e.g., Chat Health, this is a tool where an anonymous conversation can be held between a Clinician and young person. • Pre-Assessments for some patients will now be done online before they come for their operation. • Work ongoing with our communications with patients. A discussion was held on the presentation and a few points are noted below. M McGurk thanked A Graham for this presentation as is it very useful, this must be key to discussions, we must challenge that we are demonstrating we are using system the best we can. The implementation costs for some of these digital solutions are high. It is important that we capture the full financial improvement in the business case. J Tomlinson noted the integration and the existing structure and that the delivery of care. Do we have an ambition to create something in Fife re wellbeing or will be nationally? J Tomlinson provided an example of an ongoing project that has been successful. Also noting there needs to an alternative to not just digital so there is no exclusion for some that cannot access these sites. D Wilson provided comments and work to be done on communications and raising awareness to the end user. A Graham thanked for all the helpful comments this will help build on further discussions.	
7	**Business Cases / Proposals**	
	7.1 GP IT Update M Richmond delivered a presentation to update the Board on the next steps GPIT reprovisioning. NHS Fife agreed to become a Single Cohort to all GP Practices and will go to a single solution. An IA was in development. There are 2 suppliers on the framework but one of the suppliers EMIS has decided to withdraw from the national framework but will continue to support until 2026. Majority of GP Practices are on EMIS. Cegedim is now the only credited supplier, discussions are taking place with National Teams regarding this withdraw and the next steps. There is no option is a direct award.	

	We need to OBC, and we need to assess: • Development model • Agree integrations • Develop the cost profile. What will the costs be for move everyone to this system? M Richmond provided feedback on all who has been involved in these discussions. Although this is national, we are asking the D&I Board to support to go to OBC. We need engagement with GP's and National to move to with the intent to direct award. A discussion is also ongoing to extend for another possible 24 months. A brief conversation was held on now only having one supplier. L Barker provided feedback that it would be helpful to extend existing supplier for 24 months. Early engagement with the new system and support to the teams is helpful. M Richmond noted that communications will be coming out. A Graham provided some feedback to the risk but noted positivity in this outcome, we can now model on a once for Scotland. M McGurk raised concerns in terms of the deliverability and the costs. We need to review these and make part of the OBC, at present we not in a position to. This is not just about GP IT systems, this is also EMIS into Acute, NHS 24 and SAS, this is going to be a major effect through all departments. Due to the above concerns raised it was felt an initial agreement would be beneficial. M Richmond provided feedback they are working with National to see how can far they can extend the current GP supplier contractual agreement. Brief discussions were undertaken within Board, and it was noted further work requires to be reviewed it needs to be wider than this Board.	
	7.2 LIMS Full Business Case A Graham noted the business case has already been approved by Board and brought only for note and provide an update. A discussion was held at the FP&R Committee meeting on Monday 17th October, regarding LIMS and this bene highlighted to close the loop and note to Board. No comments were raised	
8	**Escalation to Clinical Governance Committee**	
	It was noted • LIMS Paper is going to Clinical Risk Committee • The presentation for "Digital First would be presented to CGC in future • GPIT presented to CGC in future.	
9	**AOCB**	
	No other point was raised. Dr McKenna thanked everyone for attending and for all continued hard work from D&I. The next Boards meetings shall be organised and provided.	

10	**DATE OF NEXT MEETING** To be arranged.	

DRUG & THERAPEUTICS COMMITTEE

(Meeting on 24 August 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Drug & Therapeutics Committee

NHS Fife

CONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 1.00PM ON WEDNESDAY 24 AUGUST 2022 VIA MICROSOFT TEAMS

Present: Dr Chris McKenna (Chair)
Mr Ben Hannan (Vice-Chair)
Dr Ian Fairbairn
Ms Claire Fernie
Dr Iain Gourley
Dr David Griffith
Dr Sally McCormack
Mr Euan Reid
Ms Andrea Smith
Ms Doreen Young

In attendance: Mrs Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Ben Hannan welcomed Dr Sally McCormack and Dr Iain Fairbairn, Clinical Directors for Emergency Care Directorate to the meeting.

Apologies for absence were noted for Dr Marie Boilson, Ms Claire Dobson, Dr Claudia Grimmer, Dr Helen Hellewell, Dr John Kennedy, Dr John Morrice, Ms Olivia Robertson, Ms Rose Robertson, Professor Morwenna Wood.

2 MINUTES OF PREVIOUS MEETING ON 22 JUNE 2022

The minutes of the meeting held on 22 June 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
No further update at present. Mr Reid to discuss with Dr Kennedy and Dr Hellewell. **ER**

Communications Process for Guidance Approved Through the MSDTC
To be taken forward by Niketa Platt, MSDTC Professional Secretary and Fiona Forsyth, Communications Specialist (Pharmacy). An update to be brought to the ADTC in October and thereafter action expected to be closed. **ER**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Reid highlighted the draft minutes from the East Region Formulary Committee (ERFC) meeting on 27 July 2022 and highlighted key points.

Two new representatives from NHS Fife have joined the ERFC (Alison Casey, Senior Pharmacist Cancer Services and Bryony Drummond, Senior Practice Pharmacist). Dr Sarah Hailwood, Consultant Rheumatologist stood down from the ERFC following the meeting on 27 July.

Three revised ERF CNS Chapter sections (Sleep, Anxiety, Depression, Psychoses & Related Disorders; Substance Dependence; and ADHD & Development Disorders) were approved. The CNS Pain section is to be updated and brought back to the ERFC in September for approval. The CNS section 3 is still under discussion and will be brought to the ERFC at a later stage. Work on the remaining ERF Chapters is progressing through the Chapter Expert Working Groups (including Woundcare, Nutrition & Blood and Malignant Disease).

A number of Formulary application submissions were approved. A Formulary application for Trixeo Aerosphere for maintenance treatment in patients with severe COPD was not approved at this stage pending clarification of the rationale for the inclusion of two triple therapy MDIs in the formulary.

The ADTC noted the update from the East Region Formulary Committee and the good collaboration across the Region. Work is progressing and it is anticipated that the initial Chapter review phase will be completed by the end of this year/early next year.

6.2 MSDTC

Mr Reid provided a verbal update on behalf of the MSDTC and highlighted key points from the minutes of the meeting on 15 June 2022.

The updated Eczema Pathway, Out of Hours Presentation of Diabetes Guidance, updated Management of Diabetes Risk with High Dose Steroids Guidance and Management of Long-Term Medications Guidance were approved. In addition a number of guidance documents were provisionally approved subject to some amendment, including the updated Rivaroxaban Counselling Record, the Heart Failure Guidance, the Anaphylaxis Policy, and the Ambulatory Human Albumin Infusion Service Guidance.

The ADTC noted the number of guidance documents provisionally approved and queried whether further support should be provided to clinicians prior to submission to the MSDTC to minimise delays in the process. It was noted

that a new template has recently been introduced which provides clear guidance on the submission format/process and support is also provided by the MSDTC Secretariat.

The ADTC noted the update and the importance of the MSDTC's role in the governance process.

6.3 Medical Gases Committee

Mr Hannan introduced the update report on behalf of the Medical Gases Committee.

The ADTC noted the good progress made in response to the Scottish Government's nitrous oxide implementation plan published in May 2022 including establishment of a Nitrous Oxide Mitigation Working Group to work towards the Scottish Government's target of zero emissions from nitrous oxide.

The ADTC noted the actions taken in response to a significant incident whereby a vehicle crashed near to a VIE tank at the Victoria Hospital. Repair works to the fence have been carried out and a stronger barrier installed. A multiagency resilience and lessons learnt review is being undertaken.

Issues identified with oxygen cylinder storage in the VHK Hospice are being addressed and work to install a new VHK hospice manifold to accommodate new W- sized cylinders is to be undertaken.

NHS Fife's response to a National Patient Safety Alert for nebulisers is being taken forward in conjunction with Estates. It was highlighted that Governance arrangements for nebulisers will move to the new Medical Devices Committee once that is established.

Graphs highlighting the fluctuations in use of CD size cylinders within VHK and the oxygen demand from the VIE tank were also noted.

The ADTC noted the update report on behalf of the Medical Gases Committee and was assured by the good medical gas governance structure in Fife in terms of reporting and monitoring.

7 SBARs

7.1 Valproate Audit and Improvement Plan

Mr Reid presented the SBAR "Valproate Audit and Improvement Plan" and briefed the ADTC on the background to this.

A multi-professional short-life working group (SLWG) was established in NHS Fife in response to the Medicines and Healthcare products Regulatory Agency (MHRA) requirement that valproate medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme (Prevent) is in place. A valproate safety audit tool

was developed to provide assurance that the requirements of the Valproate Pregnancy Prevention Programme are being met and a valproate safety audit was initially undertaken in 2020. Following the results of this the ADTC endorsed a re-audit in 2021 and the development of a Valproate Shared Care Agreement.

The ADTC noted the results from the further audit undertaken at the end of 2021. The audit results have been discussed at the Safe Use of Medicines Group and several groups have been consulted to gain an understanding of what the challenges are and further communication has been developed. Education sessions have also been delivered for Sexual Health and Midwives. Healthcare Improvement Scotland is establishing a Sodium Valproate Learning System comprising of a range of multi-disciplinary experts and stakeholders who are involved in the prescribing and dispensing of sodium valproate and NHS Fife will have representation on the membership of this group.

It was also noted that a local Shared Care Agreement will be developed and implemented by the Shared Care Group as a priority.

The ADTC noted the appendices included within the SBAR including plans for further communication and development of guidance and an action tracker outlining the plans for taking forward local improvement in the audit standards.

The ADTC noted the information presented and was assured by the actions being taken and the work underway locally. An update to be brought back to the ADTC in 6 months. **ER**

7.2 Potassium Permanganate Patient Safety Alert

The ADTC noted the paper outlining NHS Fife's response to the Patient Safety Alert - risk of inadvertent oral administration of potassium permanganate issued in May 2022.

7.3 Mexiletine Hydrochloride Patient Safety Alert

The ADTC noted the paper outlining NHS Fife's response to the MHRA Patient Safety Alert issued in August 2022: Recall of Mexiletine hydrochloride 50mg, 100mg and 200mg Hard Capsules, Clinigen Healthcare Ltd due to a potential for underdosing and/or overdosing.

8 Risk Register

It was noted that development of the ADTC medicines risk register will be progressed once the Corporate Risk Register has been finalised. There are no items within the current ADTC register that require escalation at this stage.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 Sapropterin for the Adjunctive Treatment of Phenylketonuria

Mr Reid highlighted the ADTC Collaborative (ADTCC) communication regarding sapropterin for the adjunctive treatment of phenylketonuria and briefed the ADTC on the background to this.

Sapropterin dihydrochloride (Kuvan®) was reviewed by the SMC in 2018 but was not recommended as the submitting company's justification of the treatment's cost in relation to its health benefits was not sufficient and in addition the company did not present a sufficiently robust clinical and economic analysis to gain acceptance by SMC. Sapropterin is now available as a generic product which is outwith the remit for consideration by the SMC. The cost effectiveness has changed significantly and NHS Scotland National Procurement has undertaken a procurement exercise to deliver the best value for the generic product for NHS Scotland. The ADTCC has been working in collaboration with the Scottish Inherited Metabolic Disorders Service (SIMD) to support Boards with the introduction of sapropterin and a statement for use has been produced. This is a stand-alone process and does not set any future precedence.

It was noted that as generic sapropterin is outwith the SMC remit the PACS2 application process does not apply. A Formulary application for this product in line with the SIMD statement is being progressed.

The ADTC noted the communication from the ADTC Collaborative regarding sapropterin for the adjunctive treatment of Phenylketonuria. Pharmacy to work with Finance colleagues to clarify the pathway and determine potential financial implications for NHS Fife. Mr Reid to ascertain if there is any information on expected success rate and potential benefit to individual patients. **ER/RR**

10 EFFECTIVE PRESCRIBING

10.1 Early Access to Medicine Scheme

None for noting.

10.2 National Cancer Medicines Advisory Group (NCMAG) - Abiraterone

The ADTC noted the NCMAG decision not to support routine off-label use of abiraterone acetate plus prednisolone in combination with androgen deprivation therapy for the treatment of high-risk hormone-sensitive non-metastatic prostate cancer. A re-appraisal of the NCMAG advice is anticipated when generic products become available in the coming months.

11 HEPMA Update

Mr Hannan provided a verbal update on progress with the implementation of HEPMA. The revised business case has been approved by NHS Fife Board and the HEPMA Project Board will be re-launched to take this forward within agreed timelines. A progress update will be brought back 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.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items for escalation to the Clinical Governance Committee.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 14 June 2022.** For information.

b **Minutes of Respiratory MCN Prescribing Sub-Group 21 June 2022.** For information.

c **Minutes of Heart Disease MCN Prescribing Sub-Group. Next meeting 25 August 2022**.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 12 October 2022 at 1.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 28 September.

DRUG & THERAPEUTICS COMMITTEE

(Meeting on 12 October 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Drug & Therapeutics Committee

NHS Fife

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD AT 1.00PM ON WEDNESDAY 12 OCTOBER 2022 VIA MICROSOFT TEAMS

Present:
Dr Chris McKenna (Chair)
Mr Ben Hannan (Vice-Chair)
Ms Shona Davidson (on behalf of Olivia Robertson)
Dr Iain Gourley
Dr David Griffith
Dr Claudia Grimmer
Dr Helen Hellewell
Dr Sally McCormack
Mr Euan Reid
Ms Rose Robertson
Ms Andrea Smith
Ms Doreen Young

In attendance:
Ms Geraldine Smith (Agenda items 6.5 and 7.1)
Mrs Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Dr McKenna welcomed Dr Claudia Grimmer to the meeting as representative for the Division of Psychiatry.

Apologies for absence were noted for Dr Marie Boilson, Ms Claire Dobson, Dr Ian Fairbairn, Ms Claire Fernie, Dr John Morrice, Ms Olivia Robertson, Mr Satheesh Yalamarthi.

S MacDonald to forward an updated attendance list to Dr McKenna and Mr Hannan for review. **SMacD**

2 MINUTES OF PREVIOUS MEETING ON 24 AUGUST 2022

The minutes of the meeting held on 24 August 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
Mr Reid updated the ADTC on preliminary discussions around embedding realistic prescribing within the medicines governance structure. Discussions are continuing and an update will be brought back to the ADTC in due course. **ER/AS**

AMT Update - discussion around implications of antibiotics not recommended by SMC due to non-submission

Mr Reid advised that NICE has published guidance on two antimicrobials which have not been recommended by the SMC due to non-submission. The implications for NHS Scotland are being considered and national guidance is awaited. In the interim a process for consideration of urgent requests for antibiotics not recommended by the SMC due to non-submission is in place within NHS Fife. An update to be brought to the ADTC when national guidance is available.

Shared Care of Medicines
Mr Reid highlighted an outstanding issue around resource implications for shared care. Mr Hannan to discuss with Dr Hellewell and bring an update to the ADTC in December. **BH/HH**

National Plasma Product Expert Advisory Group Communication: Immunoglobulin Availability
It was noted that the communications process has been formalised and a new section has been included in the Safe & Secure Use of Medicines Policy and Procedures. **Action closed.**

Prescribing in Renal Impairment (DOACs) - Response to MHRA Update
Mr Hannan to discuss with Fiona Forrest, Deputy Director of Pharmacy & Medicines and Lauren Gibson who has recently been appointed as Lead Clinical Pharmacist for Prescribing and bring an update to the ADTC in due course. **BH**

Risk Register
Items scheduled for review included on the agenda. To be removed from the action list. **Action closed.**

Communications Process for Guidance Approved Through the MSDTC
A Smith to discuss with Niketa Platt, MSDTC Professional Secretary and bring an update to the ADTC in December. Thereafter action expected to be closed. **AS**

Sapropterin for the Adjunctive Treatment of Phenylketonuria
Mr Reid is meeting with Finance colleagues at the end of October. An update to be brought to the ADTC in December. **ER**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Reid introduced the draft minutes from the East Region Formulary (ERF) Committee on 28 September 2022 and highlighted key points from the meeting.

A number of ERF sections were approved including Anaesthesia and revised CNS Chapter sections (Dementia, Parkinson's, MS and Neuro-muscular, Nausea and Vertigo, Poisoning, Migraine, Epilepsy, Pain). Work on the remaining ERF Chapters (Malignant Disease, Woundcare and Nutrition & Blood) is progressing through the Chapter Expert Working Groups. A number of Formulary application submissions were also approved.

It was noted that NHS Fife will be chairing and providing administrative support for the ERFC meetings in November 2022, January and March 2023.

Dr McKenna highlighted feedback from General Practitioners regarding recommendations from Specialist Nurses for medicines not included on the ERF. Mr Hannan to look into the issue and discuss with nursing leadership colleagues. **BH**

It was noted that work around Formulary compliance had been paused during the transition to the ERF and this will be progressed in the New Year. Formulary compliance prior to the move to the ERF was very good across Primary Care and Secondary Care.

The ADTC noted the update from the East Region Formulary Committee and the good progress made.

6.2 MSDTC

Ms A Smith provided a verbal update on behalf of the MSDTC and highlighted key points from the minutes of the meeting on 24 August 2022.

A new template for submissions has been introduced which has led to an improvement in the content of submissions. Several submissions were approved including the revised Inflammatory Bowel Disease Guideline (provisionally approved subject to minor amendments), Guideline for Combined Hormonal Contraception/Hormonal Replacement Therapy for Women having Planned Surgery, Dermatology Eczema Pathway and Baricitinib for the Treatment of Covid 19 Guidance. A request for a midwives' exemption for ferrous fumarate to allow midwives to be able to supply women with their oral iron supplement early in their pregnancy was also approved.

It was noted that Dr Sally McCormack will take over as Chair of the MSDTC from Professor Morwenna Wood from November onwards. Ms Smith thanked Professor Wood for her role in supporting the MSDTC.

The ADTC noted the verbal update and minutes from the MSDTC meeting on 24 August.

6.3 Fife Prescribing Forum

Mr Hannan introduced the update report on behalf of the Fife Prescribing Forum.

A number of Specialties have attended the Prescribing Forum since April 2022 (Planned Care, Neurology, Renal, Endocrine / Diabetes, Community Health, and Respiratory) to present their Service Updates. There has been good engagement from Clinicians and Service Managers and excellent detailed reports have been produced. The Forum continues to evolve and the next step is working with Finance to ensure that horizon scanning feeds in the Strategic Priorities Resource Allocation process.

The ADTC noted the update report on behalf of the Fife Prescribing Forum and the good progress made to support the medicines financial planning process.

6.4 PGD Group

Mr Reid introduced the update report on behalf of the PGD Group and highlighted key points.

It was noted that there has been a great deal of activity post COVID-19, particularly around vaccines. Since the last update report in April 2022 60 PGDs across a number of different clinical areas and 10 Hospital at Home PGDs have been reviewed and approved. There have been 10 new amendments to the COVID-19 PGDs, an amendment to the two Influenza PGDs and 11 vaccine PGDs have been updated as part of the Vaccine Transformation Programme.

The ADTC noted the challenges around increasing workload and response time for reviewing/approving PGDs due to services continuing to be very busy.

The ADTC noted the update report on behalf of the PGD Group and the good progress made supporting Hospital at Home and the vaccine service.

6.5 Safe & Secure Use of Medicine Group

Mr Hannan introduced the update report on behalf of the Safe & Secure Use of Medicine (SSUOM) Group and highlighted key points.

It was noted that the SSUOM Group will now meet every second month. A new Controlled Drug Governance Group has been established as a subgroup of the SSUOM Group, with the first meeting of this subgroup focusing on a detailed scrutiny of controlled drug incidents.

Achievements since the last update include recommencement of the rolling programme of review of the Safe & Secure Use of Medicines Policy & Procedures (SSUMPP) sections. The workplan for the next six months includes the launch of version 11 of the SSUMPP and the review and approval of the audits due to be completed in 2022.

The ADTC noted the update report on behalf of the SSUOM Group and the achievements made.

Terms of Reference

It was noted that some minor amendment was required to the Terms of Reference and this will be brought back to the ADTC in due course for approval.

Fridge Audit

The ADTC noted the Medicines Requiring Refrigeration Audit of Queen Margaret and Victoria Hospital and the actions undertaken/proposed in response to this.

6.6 Controlled Drugs Local Intelligence Network / Controlled Drug Accountable Officer Annual Report

G Smith introduced the update report on behalf of the Controlled Drugs - Local Intelligence Network and the Controlled Drug Accountable Officer Annual report.

The report detailed the activities that have taken place during April 2021 to March 2022 and the progress made including completion of the Pharmacy Controlled Drug Ward Audit, revision of the CD Authorised Witness Standard Operating Procedure to incorporate COVID-19 Guidelines and establishment of the East Region CD-LIN. NHS Fife chaired the East Region CD-LIN in May 2021 and also delivered a presentation on procedures for drug related deaths. Following the presentation information was subsequently shared across the three Boards in the East Region. A second regional CD-LIN was arranged for November 2021 with the NHS Fife Governance & Security Officer leading a discussion on the sharing of information between Boards.

A discussion ensued around the results of the controlled drug ward audit. A number of detailed recommendations and actions have been agreed which will be taken forward with individual wards and departments where areas of non-compliance have been identified. The ADTC was assured by the stringency of the audit, the low level of risk identified and the actions taken/proposed to support learning and improve compliance. The high level of reporting of incidents around controlled drugs is welcome and should be encouraged. There was a discussion around the limitations of the audit tool and whether the tool was fit for purpose going forward.

The ADTC thanked G Smith for the important work ongoing to support the safe and effective use of Controlled Drugs within Fife. Further analysis of the data within the report will be undertaken and the report updated accordingly before the report is presented to EDG and the NHS Fife Clinical Governance Committee.

7 SBARs

7.1 Medication Incident Annual Report

G Smith introduced the Medication Incident Annual Report and briefed the ADTC on the background to this. The report covers the period April 2021 to March 2022 and is based solely on incidents reported via Datix. This is the first time that this report has been produced and it has been brought to the ADTC for discussion and to note the work ongoing to ensure the safe and effective use of medicine within Fife.

The ADTC noted that there is a similar level of Datix reporting across both the Acute Service Division and Health & Social Care Partnership. The report outlines the number of Datix incidents reported and the severity of the incidents and it was noted that no real themes or trends were identified. The report details a number of actions taken/planned for the next 12 months including a dalteparin medicines safety huddle and medicine safety work around insulin and anticoagulants. The Antimicrobial Pharmacist is also undertaking a more detailed analysis of reported antimicrobial incidents.

The ADTC noted that the report highlights the good culture of reporting of medication incidents within NHS Fife. Going forward it would be useful to include information on the number of drugs administered.

The ADTC thanked G Smith for producing the Medication Incident Annual Report. It was suggested that the data be shared with Clinical Directors and Heads of Nursing with a request to work collaboratively with Pharmacy to identify any learning needs going forward. **GS**

8 Risk Register

Mr Reid took the ADTC through the risks scheduled for review:

Risk 1621 - Medicines Shortages
Risk 522 - Prescribing Budget

Following discussion it was agreed that risks 1621 and 522 should be reframed to reflect the reality of the medicines budget overspend, the risk of long-term financial sustainability and the potential clinical risk resulting from this. To be articulated into new risks for Primary Care and Secondary Care.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

9.1 ADTC-Collaborative Newsletter August 2022

The ADTC noted the ADTC-Collaborative Newsletter August 2022.

9.2 Yellow Card Centre Scotland Annual Report

The ADTC noted the Yellow Card Centre Scotland Annual Report.

10 EFFECTIVE PRESCRIBING

10.1 Early Access to Medicine Scheme

None for noting.

11 HEPMA Update

Mr Hannan advised that the HEPMA team is in the final stages of signing the contract.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

It was agreed that the CD-LIN Annual Report should be submitted to the Clinical Governance Committee. Dr McKenna and Mr Hannan to discuss further prior to submission. **CMcK/ BH**

14 ADTC Provisional Meeting Dates 2023

The ADTC meeting dates for 2023 were noted. These are provisional subject to issuing of the corporate calendar of meetings.

15 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group 27 September 2022** - not available

b **Minutes of Respiratory MCN Prescribing Sub-Group.** August meeting cancelled.

c **Minutes of Heart Disease MCN Prescribing Sub-Group 25 August 2022**. For information.

d **Minutes of Safe & Secure Use of Medicine Group 24 May, 20 September 2022**. For information.

e **Date of Next Meeting**
The next meeting is to be held on **Wednesday 7 December 2022 at 1.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 23 November.

QUALITY & COMMUNITIES COMMITTEE (Meeting on 9 September 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 09 SEPTEMBER 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 Ian Dall (ID)
Attending:	Kathy Henwood, Head of Education and Children's Services (Children and Families/CJSW and CSWO) (KH) Lynn Barker, Director of Nursing Catherine Gilvear, Quality Clinical & Care Governance Lead Lynne Garvey, Head of Community Care Services (LG) Roy Lawrence, Principal Lead for Organisational Development & Culture (RL) Kenny Murphy, Third Sector Representative (KM) Simon Fevre, Staff Side Representative (SF) Rona Laskowski, Head of Complex and Critical Care Services (RLas) Morna Fleming, Carer's Representative (MF) Allan Adamson, Service Manager, Contract & Commissioning Team (AA) Lesley Gauld, Team Manager, Strategic Planning (LG) Heather Bett
In Attendance:	Jennifer Cushnie, PA to Associate Medical Director (Minutes)
Apologies for Absence:	Nicky Connor, Director of HSCP Dr Chris McKenna, Medical Director Dr Helen Hellewell, Associate Medical Director Ben Hannan, Director of Pharmacy and Medicines Paul Dundas, Independent Sector Lead 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, in particular, Morna Fleming who is the Carer's Representative. SB ran through the protocol for the meeting. SB acknowledged the passing of Queen Elizabeth II and thanked the tremendous hard work and dedication from all of the Health & Social Care Staff across NHS and Parntership in what continues to be a very challenging environment.	
2	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
3	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
4	**MINUTES OF PREVIOUS MEETINGS HELD ON 05 JULY 2022** The previous minutes from the C&CGC meeting on 05 July 2022 were approved as an accurate record of the meeting. MB queried if the group was quorate and, for those who were unable to attend, had a representative been nominated to attend in their place? It was confirmed the Group was quorate. SB advised Alan Adamson was attending for Fiona McKay as there was a Paper to be presented. MB asked if this issue could be followed up out-with the meeting.	**WA**
5	**GOVERNANCE**	
	5.1 HSCP Annual Performance Report 2021-2022 AA presented the Paper which was brought to Committee for assurance. She stated this was the Partnership's 5th Performance Report covering 2021-22 and the last of the current Strategic Plan. He advised there had been some significant changes internally and externally during the year, ie ongoing impact of the pandemic, cost of living crisis and challenges within workforce recruitment. He told of a restructure within the Department and the reasons. The 5 Strategic priorities were outlined with a case-study which demonstrated progress in these areas. He highlighted the Report does not encompass all the work carried out by the Partnership, but rather key examples to give an overview of the range of outcomes which have been delivered. Overall, the report was felt to be a positive report, despite challenging times. It gives a strong foundation for the new Strategic Plan for 2022-2025, which will be published later in the year. AA introduced Lesley Gauld, Team Leader, Strategic Planning and indicated he and Lesley were happy to answer questions. Cllr Liewald commented she was delighted with the positive work taking place and acknowledged there was much to be done but felt the Paper was a fair representation.	

	Cllr Kennedy agreed with Cllr Liewald's comments and praised the innovative thinking during the pandemic and was confident through development of the new strategy, the Partnership is in a good position to move forward.	
	Cllr Downie was keen to see further detail around working with deaf/blind groups. AA advised the deaf communication service is an area which is being built upon and there is work going on to support individuals and their carers. LG will forward further information to Cllr Downie.	**AA / LG**
	MB sought clarification around people using the Wells Unit. AA stated this was affected by the pandemic and will forward further information to MB. The communication strategy was queried and it was felt this must be robust. Rehabilitation was also queried and MB pointed out the East of Scotland have a very poor record of residential rehabilitation compared to the rest of Scotland. He referred to funding available and felt a rethink is required. SG queried if there is word of any developments coming from Scottish Government level. AA stated he could not comment but felt NC can advise MB. This topic was discussed at some length.	**AA**
	Cllr Liewald asked if feedback could be provided by Elisabeth Butters, NC and RLas from the Alcohol and Drug Partnership Group to attend a future meeting. A development session was to be considered.	
	Cllr Steele was delighted to see mention of the vital work of the NNPI Service. She enquired if there is CPR staff training for picking up Sepsis and Osmosis post Covid infection in the black and minority ethnic groups. LB advised there is a huge amount of work ongoing within the Immunisation Programme re minority groups and she will give a detailed response through email outwith the meeting.	**LB**
	MF was happy to see the detail around unpaid carers and was pleased the Booster Programme is rolling out. She stated there has been an agreement with COSLA that unpaid carers should be included in the equality and diversity impact assessment in any report. She has passed the letter to NC and FMcK and would like to see this in future report SBARs. This has been raised previously and expects this to be included in future. SB asked MF to keep her informed.	
	ID asked if Appendix 2 details the full list of indicators. AA advised the indicators are received through the ?? Team, a new update will be received early September. The report will be updated before presentation to IJB. ID queried post diagnostic support for Alzheimers. AA advised it was difficult to include all key themes in the report and it was agreed this is one of the top 3 problems within Fife. AA advised this will be considered for inclusion in the final report. SB agreed, it would be helpful.	
	Cllr Downie queried why access to Abortion Services is not included. LG stated this is not a Partnership Service and sits with Women & Children's Directorate in Acute NHS. Heather Bett, Service Manager Sexual Health Services will link with Cllr Downie.	**HB**

	MB stated he is not comfortable with percentages used in the report and prefers numbers be used. SB was in agreement and AA advised these comments will be taken on board. SB commented Shared Lives Fife is an excellent piece of work and questioned background checks. AA advised PVG and background checks will be conducted, however, AA will put SB in touch with the relevant Service Manager. SB sought further information around the Learning Disability Service which paints a positive picture, however, referred to recent media reports to the contrary. AA advised RLas was the best person to answer such queries, however, did know of plans in place. SB will liaise with RL separately.	**AA** **HB**
	5.2 Fife HSCP Year 1 Workforce Action Plan 2022-2023 RL introduced the Plan which he asked the Committee to consider and discuss. Support for the recommendation the IJB approve the Plan was also sought. He advised the Plan will go to the IJB at the end of the month. There is no requirement for the Plan to be submitted to Scottish Government, it is an internal Action Plan for Fife HSCP to deliver on the Strategy. He stated the Plan will come to SLT Assurance 3 times annually and the IJB annually, LPF and Committees. Feedback from Scottish Government is awaited on the Final Strategy, this is expected imminently. RL outlined the key points within the Action Plan and how it aligns with the priorities of the Strategy. He explained the work which is currently being carried out and invited comments / questions. Cllr Kennedy queried if the action plan will enable employees, rather than the System leading and asked if Staff-Side are in agreement. RL gave assurance there will be engagement with the workforce and management will be coached to allow this culture to flourish. Cllr Kennedy was encouraged to hear the 'softer' skills in people management will be available to Senior Staff. SF was supportive of the Plan. Cllr Liewald was pleased to hear of the joined up communication across all staff and particularly glad to see plans around housing provision and OT services. MF would like to see a dedicated group of professionals attending the Locality Planning meetings in each of the 7 Localities - consistency to help build relationships. She also asked, if there is funding available, can funds be used to improving pay and conditions for Social Care Workers to encourage retention and attract new employees. RL advised the SLT members are aligned to a Locality which will give assurance around continuity. Regarding recruitment, RL told of work to improve pay and conditions for Social Work Carers and the ongoing effort. RL will link with MF out with the meeting. LG added, there was incentive given to external providers to enhance rates and some Scottish Government funding was dedicated to	**RL**

	weekend working and enhanced rates within the Private Sector. She told of work taking place to retain Carers around working conditions, not just pay and also told of an ITV campaign and locality targeted advertising campaign to enhance recruitment. ID welcomed the report, he would like to see more on staff retention, considering all conditions and benefits for employees, not just salary. He would like to see if monies coming in from Scottish Government could help to enhance Carers' salaries. MB felt it is vital to remember the rate of pay is very important and also the opportunity to develop within the post as well as job satisfaction. RL thanked all for the feedback.	
	5.3 Child Protection Annual Report : Child Protection Committee AS, Independent Chair of Fife Child Protection Committee introduced the report. He explained the period covered is the academic year from 01.4.20-31.07.21. The report covers a critical and difficult time due to the world-wide Pandemic and AS spoke of the particular difficulties this brought to children and families and how some of these difficulties were overcome. AS told of resource issues within the Committee through the absence of a full time Lead Officer at the beginning of the pandemic. He explained how the work was taken forward despite the isolation caused by lockdown and how the Service adapted. MS Teams was widely introduced to carry on communication of operational meetings, working groups and committees. AS spoke of new Child Protection Guidance which was introduced in Sept 2021. A significant change programme has been implemented relating to the Guidance, which AS elaborated upon. KH added, Child Protection does not work independently but relies on everyone being alert to children, families and vulnerable adults in their own communities, helping to build safer communities, safer families and supports. A key factor is the increase in poverty, which is having a huge impact on families. KH told of joined up working across the Partnership - support for families with practical resources and enabling emotional resilience there can be a reduction in the instances of child harm from parents and people in the community. MF referred to the unexpected increase in CAMHS referrals and asked if there is a mechanism for maintaining contact with the adolescents until they can access the therapies needed. She also asked if there is an issue with children not returning to school after lockdown and if so, how this is being tackled. KH advised an increase in referrals to CAMHS was anticipated and through the Community Health and Wellbeing Fund, support has been set up for children and adolescents to access services, without clinical assessment. She explained the multi-agency support which is being provided for children/adolescents whilst awaiting additional	

	support through CAMHS. Additionally, KH described the various mechanisms in place to support children and adolescents with care experience. Regarding children who have not returned to school post lockdown, KH advised this issue is actively being addressed and information is presently being collated. She stated some children may have reached an age or stage to migrate away from education, however, every child on the school register pre lockdown will be accounted for. RLas stated, an Urgent Referral Team has been established and she assured high risk children and adolescents are being picked up immediately, and also those who have been waiting the longest. She stated the waiting list for this group has reduced by half since the start of the year.	
	5.4 Revisited Child Protection Guidelines	
	HB introduced the Paper which relates to the previous presentation by Alan Small. The purpose of the Paper is to give assurance to the Committee of the structure in place to implement the new guidance within Fife HSCP, also with links into Acute. She told of a Local Group established to take forward the changes and how the group is working to understand the implications for service delivery within HSCP setting. She stated the responsibility does not rest solely with the Child Protection Team but across all Services, particularly within Adult Services who are working with families and can assess for risk to children within these situations. HB outlined the various workstreams set out in the paper and how they link together with multi-agency services and partnerships. She told of Quality Improvement Officers working to ensure the quality of service and its relevance. MB queried if HB felt confident electronic communication systems between all agencies are compatible and was she confident data protection would not be breached. HB advised there is an information sharing protocol being worked on currently with input from information governance teams. Officers will add information to a standalone system which provides full information on the case being considered. Currently, paper records are held in all 3 Agencies, these will be manually entered onto one electronic record which can be see remotely by each Agency. The issue of a possible cyber-attack was discussed and HB described how this will be minimised. KH added, the system has been tested across England and local authorities within Scotland and it is compliant with the Police standard of security. She assured, in Fife, it will be ensured the system meet all regulations and parameters of security. Cllr Kennedy was particularly pleased to see the definition of neglect has been revised and also Health will be an equal partner. SB was also very pleased to see Health now an equal partner.	

6	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	6.1 Unconfirmed Minute of the ADTC from 22.06.22	
	6.2 Minute of the Clinical Governance Committee from 01.07.22	
7	**ITEMS FOR ESCALATION** No items for escalation.	
8	**AOCB** No further items raised.	
9	**DATE OF NEXT MEETING – Tuesday 8th November 2022, 1000hrs MSTeams**	

Health & Safety Sub-Committee (Meeting on 2 September 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Health & Safety Sub-Committee

Minute of the H&S Sub-Committee Meeting
Friday 2 September 2022 at 1.30 pm on Teams

Present
Neil McCormick (Chair), Director of Property & Asset Management (NMcC)
Dr Chris McKenna, Medical Director (CMcK)
Conn Gillespie, Staff Side Representative (CG) (Joined meeting at 1.40 pm)

In Attendance
Paul Bishop, Head of Estates (PB)
Billy Nixon, H&S Manager (BN)
Ann-Marie Marshall, Acting Senior H&S Advisor (A-MM)
Kevin Reith, Deputy Director of Workforce (KR) for Linda Douglas
Rona Laskowski, Head of Complex Critical Care Services, Fife HSCP (RL)
Andrea Barker (AB) Minute

The meeting was recorded on Teams

The order of the minute may not reflect that of the discussion

No.		Action
1.	**Welcome & Introduction** NMcC welcomed everyone to the meeting and introduced Billy Nixon, H&S Manager and Rona Laskowski, Head of Complex & Clinical Care Services, Fife HSCP.	
2.	**Apologies** Apologies were received from Linda Douglas (Kevin Reith).	
3.	**Minute/Matters Arising**: 3.1 Minute of Last Meeting of 10.06.22 was recorded as accurate. 3.2 Minute of Meeting of 13.07.22 (W McConville, Unison H&S/V&A concerns to CP dated 08.06.22) was recorded as accurate.	
4.	**Covid-19 Update**: 4.1 SBAR Covid-19 HAI HSE Spot Inspection (JO) (dated April 2021) & 4.1(a) Attachment: Action Plan (CW) Noted by the group. All actions were undertaken on the Action Plan. No formal Improvement Notice was issued by the HSE. Now closed. **Action** – One or two actions require to be closed off on the Action Plan in	**NMcC/**

	order to finalise the document and to have a complete version for the record.	**BN**
5.	**<u>Governance Arrangements</u>**: 5.1 <u>H&S Services Report</u> NMcC advised that moving forward, he had agreed to BN's staffing proposal for the H&S Department. He added that there was a slight increase in resources required, however, this will be managed within existing budgets given its importance. **<u>Action</u>** – BN to present the proposed H&S staffing arrangements to the next H&S Sub-Committee meeting on 09.12.22. (a) <u>Manual Handling (MH) Plan Moving Forward</u> • MH department restructuring plan underway. • Plan for a sustainable, evidence based service. • Training plan/rota created which reflects the needs of the service 5 days a week (with contingencies built in). • The MH delivery model addresses and positively impacts on the divide between the acquisition phase of training and the application phase. • Contingency slots have been fitted into the rota to allow a proactive, not just reactive service. • Positive H&S culture adopted. • Best practice is known and shared. • Staff are supported and developed (training, qualifications to fulfil their potential). <u>Manual Handling</u>: • Link worker role is considered to provide support at ward level. • Link worker role and responsibilities defined. • Link workers interested in the role assessed for suitability and endorsed by SCNs. • Training Course with appropriate aims and learning outcomes. • MH team to run the course to ensure staff are able to fulfil their role. • Link workers assessed by MH Team - evidencing knowledge, understanding and skill of the link worker. <u>Management and support of Link workers</u>: • Mandatory refresher course. • Frequent support visits by MH Team. • A support group set up for all link workers and MH Teams. • Data base/spreadsheet created and maintained by Administrator to ensure staff and areas are monitored • Link worker role creates potential career progression, encourages staff to consider a post within the dept or similar roles in other areas. (b) <u>Audit/Training Needs Analysis</u> • MH Policy and associated procedures reviewed. • Manual handling audit work commenced to ensure the team are meeting service requirements and Scottish Manual Handling Passport. • Self assessment forms produced for patient and non-patient	**BN**

handlers.

- Review and update all current MH paperwork/certificates etc.
- Review and update all generic manual handling risk assessments available on Stafflink.
- A-MM is in the process of developing a Manual Handling Audit which will be based around the passport which will give an indication of the service and requirements. Self-assessment forms have been drawn in for patient and non-patient handlers which can be co-ordinated on ward/department level by the SCN or Line Manager. These forms will identify training requirements per member of staff.

(c) HSCP Ligature Works

- Ligature Risk Assessments are on-going.
- The formation of the new Ligature Mitigation Project Team has begun.
- H&S team involvement within an established Project Team has yet to be decided.

(d) Face Fit Testing (FFT) (Covid/Monkeypox)

The requirement for FFT has reduced significantly therefore, staff test sessions have been reduced to one per month.

(e) Sharps Strategy Group

A-MM advised that it was still proving difficult to move forward with this group given low membership/attendance with the requirement to restart the meeting a priority.

The matter was raised again at the August meeting of the ASD & CD LPF. A-MM to provide Andrew Verrecchia and Claire Dobson with a list of missing representation who have agreed to take forward with the individual department/ward.

NMcC added that given the importance of the Sharps Strategy Group, it was necessary to have nursing colleagues on board with the violence and aggression statistics. The main focus is on the VHK site with a lesser number of incidents occurring at QMH.

(f) Sharps Strategy Training Packages (A-MM)

A-MM advised that it was still proving difficult to move forward with this group given low membership/attendance with the requirement to restart the meeting a priority.

To progress with the training packages, a list of all medical sharps used in Fife together with the name of the manufacturer is require which will allow for a sustainable training package to be formulated with assistance from the manufacturers/medical reps. This will then be rolled out at ward level and maintained by the Senior Charge Nurse, Team Leads etc.

Action – NMcC to take forward and discuss with Paula Lee, Interim Head of Procurement. **NMcC**

5.2 H&S Incident Report (Apr-Aug 2022)

	• The H&S Incident Report covering the period 1 April to 27 August 2022 was presented to the group by A-MM. During this period, 37 sharps incidents were recorded overall. Of this figure, 26 incidents were recorded in Acute Services. No RIDDOR reportable injuries were recorded. • RIDDOR is reported on Datix. Following a discussion around incorrect reporting by staff, on occasion, not attaching RIDDOR reports to their Datix form, NMcC proposed that the link to RIDDOR be taken off the Datix form altogether. The proposal was endorsed by the group. **Action** – A-MM. Official guidance on the change to the Datix form will follow through to workforce via forums, meetings, Communications via Staff Link. • **Action** – A monthly RIDDOR comparison report will be introduced at the next meeting and future meetings thereafter by BN. Violence & Aggression (V&A) • V&A incidents towards staff amounted to 575 for the period April to August 2022. • NMcC commented that V&A is more prevalent in HSCP than anywhere else. RL added that in the HSCP, workforce fragility is higher in areas of mental health where there is a greater dependency on Bank or Agency staff. • RL added that in the HSCP permanent training is on-going with courses constantly available and constantly full for permanent members of staff. Substantive members of staff, however, are vulnerable in this respect. • A-MM added that If V&A were to be a standard mandatory training requirement throughout Acute, Learning Disabilities and Mental Health then the uptake would improve, however, this is something that has never been able to be achieved to date. • 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 mandatory standards across the whole of the sector. Ideally, mandatory training would need to be role specific, however, this would add to the complexity of the task. If we were to initially set a standard and from there focus on group roles in order to identify specific training requirements ie in a patient facing role. KR added that he would be happy to take part in the mandatory training proposal and it may be worth a discussion out with the meeting in order to progress. **Action** – NMcC requested that consideration be given to the preparation of a proposal for the next meeting around Mandatory Training Standards to include all staff (role specific) by taking into account the pros and cons in relation to the best way forward across	**A-MM** **BN** **RL/ BN/ A-MM**

	HSCP & NHS Fife. • Following a recent incident involving someone brandishing a knife, PB advised that as a precautionary measure, blue reflective stab proof vests have been ordered for security personnel. 5.3 Manual Handling Training Plan A-MM presented a training plan on manual handling to show projections once a full complement of H&S staff are in post. NMcC added that there are several audit findings around manual handling that require to be attended to and once a manual handling training plan is in place then this will help address these.	
6.	**NHS Fife Enforcement Activity** No H&S Executive enforcement activity to report.	
7.	**Policies & Procedures** 7.1 H&S Policy (Review date - November 2022) Please let BN know of any changes/amendments you may have. **Action** – Update H&S Policy for next meeting for approval by the group. Updates to Terms of Reference (ToR) include: • RL to be added to the membership of the group – update ToR • Streamlined group - to be clarified Post Meeting Note – amendment to name of group received from RL & forward to BN on 05.09.22 for information	**ALL** **BN** **Andrea** **Andrea** **Andrea**
8.	**Any Other Business** 8.1 Lone Working Policies RL – Deep dive across NHS Fife and HSCP around existing policies and our adherence to them. 8.2 Datix Incidents Moving forward, A-MM proposed bringing in Datix incidents to quarterly H&S Sub-Committee meetings with a view to concentrating on one specific topic for discussion. The proposal was agreed by the group. **Action** - A-MM to take forward.	**A-MM**
9.	**Date & Time of Next Meeting** Friday 9 December 2022 at 12.30 pm on Teams	

	Post Meeting Note: LD will be on annual leave and has submitted her apologies for the 09.12.22 meeting. A member of the Workforce team will cover and attend – details tbc. The newly appointed Director of Workforce, David Miller has been added to the group membership.	

MEDICAL DEVICES GROUP

(Meeting on 16 August 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Devices Group

Minute of the Medical Devices Meeting held on Tuesday 16th August 2022 at 14:30 on TEAMS

Present

Christopher McKenna, Medical Director (Chair) (CMcK)
Rose Robertson, Assistant Director of Finance (RR)
Neil McCormick, Director of Property & Asset Management (NMcC)
Iain Forrest, Medical Physics Manager (IF)
Maxine Michie, Deputy Director of Finance (MM)
Scott McNiven, Procurement Manager (SMcN)
Claire Fulton, Lead for Adverse Events, Clinical Governance (CF)
Paul Smith, Risk Management Co-coordinator, Clinical Governance (PS)
Miriam Watts, General Manager, Primary Care (MW)
Julia Cook, Infection Control Manager (JC)
Robyn Gunn, Head of Laboratory Services (RG)
Amanda Wong, Director of Allied Health Professionals (AW)
Kevin Booth, Head of Financial Services & Procurement (KB)
Alistair Graham, Associate Director Digital & Information (AG)
John Brown, Head of Pharmacy (JB)

Graeme Fawcett, Minute Taker

The meeting was recorded on Teams

The order of the minute does not necessarily reflect that of the discussion

		Action
	APOLOGIES Apologies were received from Murray Cross and Gemma Couser **Welcome and Introductions** CMcK welcomed everyone to the first Medical Devices Group Meeting And introductions were made by everyone present.	

1.	**TERMS OF REFERENCE** The draft terms of reference taken from Forth Valley's TOR's were discussed to see if they meet the requirements of this group with suggestions and recommendations invited from the group members on what the function of this group should be. CMcK stated that the purpose of this group is to ensure that there is a systematic approach to the purchasing, deployment, training, maintenance, repair and decommissioning of reusable medical equipment within the board. It will ensure that all associated risks with the acquisition and use of this equipment is minimized. IF questioned whether there would be a possible overlap of the Capital Equipment Management Group to which RR stated that the Capital Equipment Management Group does not look at mitigating action so there will be a lot of value to this group in regards to governance of the equipment, how equipment is deployed and all the associated risks. The Capital Management Group's main purpose is to agree the prioritization of capital commitment spend in line with budget allocations which are assigned through the bidding process. RR will forward a copy of the Terms of Reference for the Capital Equipment Management Group to this group for information following this meeting. - **Post Meeting Note** this has now been distributed for information to group members. Discussions took place on any risks which will be dealt with through the respective service and any new risks identified within the service with respect to the introduction of new equipment. NMc stated that the Equipment Management Group probably undertakes a lot of the stuff identified in item 5.1 of the Agenda (Policy For Property & Asset Management in NHS Scotland) which is CEL2000 for medical equipment. Discussions regarding the Terms of Reference stated that it should include something about the purpose of the Medical devices group to ensure that there is a strategic approach to this – it was also suggested that the term purchasing should be replaced with procurement. MM suggested that this group could sit above the Capital Equipment Group, CEL35, MHRA and the SHTM as it encompasses everything from Procurement, to training, to disposal of the actual equipment itself. The group will be responsible for producing an acquisition strategy ensuring that there is a strategic approach to purchasing, deployment, training, maintenance, repair and decommissioning.	

	As equipment is obtained through various channels of purchasing , gifting and charitable donations, acquisition is deemed an appropriate term to use. All equipment is to be considered Medical devices including software. IF raised the point that the line in the draft Terms of reference "The role of the Group will also cover the formulation, review and updating of policies and procedures relating to medical Equipment" could be removed as the Capital Equipment Management Group does not consider revenue equipment and there has been numerous instances over the years where have been large volumes of revenue equipment. He suggested that where large volumes of equipment are to be replaced that his group should have input. CMcK agreed and stated that this group could commission a short life working group to look at certain replacement programs. SMcN stated that he would share with the group the Terms of Reference that he has for the Medical devices group in Tayside which may be of interest to the group. - **Post Meeting Note** this has now been distributed for information to the group members. RR stated that in the draft terms of reference it suggests that this group reports to the Clinical Governance Committee and that if we were to remain with a separate CEMG then how does the output from this group feed into CEMG. CmcK stated that he did not have an answer right now but that this may come out as the group develops. SMc stated that both groups were definitely needed as this particular group wouldn't make the decisions that CEMG make, so CEMG is still needed to undertake the final part. A line in the terms of reference is also needed regarding the importance of the standardization of medical equipment across Fife. NMcC stated that a standard definition within the Terms of reference of what a Medical device is needed, as medical equipment is a broader term often used. IF stated that various bodies like the World Health Organisation deem that medical equipment is a subset of medical devices and that the term medical devices is exceptionally broad with other subsets like Software also included. PS stated that he has a list of definitions from National Services Scotland that he would send to the group which includes all the types of equipment and also includes examples in vitro diagnostic medical devices , social care equipment, estates equipment and PPE.	PS

2	**COMPOSITION** 2.1 Discussions took place on should be part of this group. CmcK stated that he was happy to chair the group with NMcC being the Deputy with representatives from the following services to make up the group. ➢ Medical Director (Chair) ➢ Estates -Director of Property & Asset Management (Deputy Chair) ➢ Finance –Deputy Director of Finance ➢ Medical Physics – Medical Physics Manager ➢ Woman & Children's Directorate ➢ Planned Care ➢ Emergency Care Directorate ➢ Quality and Clinical Governance ➢ Infection Control ➢ Risk Management ➢ Pharmacy ➢ Laboratories ➢ IT ➢ Radiology ➢ Social care Partnership ➢ Allied Health Professionals ➢ Procurement CmcK will contact Nicky Connor to get representation from the Social care Partnership MM will contact Lynn Campbell for a Acute Nursing Rep nomination 2.2 The line stating that All members of the NHS Fife Board shall have the right of attendance & access to papers should be removed from the draft TOR's. 2.3 The line stating the event of members being unable to attend, a deputy should be sought to attend on the members behalf should remain. 2.4 The line stating that the group will be supported by the Medical Directors Personal Assistant should be removed.	CMCK MM

3	**ROLE & REMIT** **3.1 Objectives** The Medical devices group will be responsible for the strategic Management of medical devices, development at implementation or procurement, maintenance and replacement procedures and issues that comply with the relevant guidelines highlighted within CEL35(2010) and other IPC standards. A new Health Facility Scotland SHTM0004 was published in June 2021and may also sit alongside the CEL 35. The groups remit will include advising NHS fife as required on the acquisition of medical devices and equipment. This will include comparisons of alternatives, reliability of ongoing support and the opportunities to rationalize the number of model types, technical specifications, regulatory compliance information and related issues. This will also include financial data, including consideration of full recurring maintenance and consumable costs. RR stated that when capital equipment requests are looked at revenue costs are asked for and how these are going to be covered. Replacement costs ought to be covered to extend those budgets already in place. Disposal costs and disposal routes and options are not covered and the Terms Of Reference should have something in it regarding disposal, particularly in regard to any green initiatives that can be followed. SMcN stated that this could be built into the technical specifications when asking for energy consumption as part of the scoring mechanism and the tender itself. Coordinating the medical device and equipment inventory including the core data set including the asset management policy and any other data required by the scan to me program will identify what equipment has been allocated to a patient and the serial number can track the equipment back providing governance. Having an oversight of systems to monitor staff training records maintained by service managers thus ensuring staff are appropriately trained in the use of equipment staff training records may provide assurances that staff are properly trained in the use of equipment. JC stated that there used to be competencies that were signed off for any new equipment that came in, but this is an area that would need to be looked at and that it would be a huge undertaking so that all information is held in one place preferably digitally.	

	IF stated that while it would be good if the group have oversight of this, but the responsibility for keeping the records and ensuring that training is completed lies with the departments but direction on what training they need and what records they keep should come from this group. A statement in the TOR's saying that the organisation has a system in place to monitor staff training in respect to medical devices was recommended. Ensuring that action is taken in relation to advisory guidance and directives issued by Scottish Government Health Directorate(SGHD) and any other regulatory body – It was agreed that this should now state Scottish Government instead of Scottish Government Health Directorate(SGHD).	
4.	**MEETINGS AND REPORTING REGULATIONS** 4.1 It was agreed by the group that meeting should be held quarterly 4.2 The quorum for any meeting will be half the membership was agreed 4.3 The NHS Fife Medical Devices Group will report to the Clinical Governance Committee was agreed 4.4 In order to fulfill its remit, the group will escalate identified risks or issues of importance to the NHS Fife Clinical Governance Committee 4.5 A Governance assurance statement will be submitted to the NHS Fife Clinical Governance Committee	
5.	**FOR INFORMATION** The following documents have been circulated for information & noting only 5.1 Policy for Property and Asset Management In NHS Scotland 5.2 Managing Medical Devices 5.3 Equipment Bids Priority Scoring 5.4 Government response to consultations on the future regulations of medical devices in the United Kingdom	

6.	**MINUTES FOR NOTING** The following Minutes have been circulated for information & noting only 6.1 Capital Equipment Management Group 21 April 2022 6.2 Capital Equipment Management Group 2 June 2022 6.3 Capital Equipment Management Group 7 July 2022 - cancelled	
7.	**ANY OTHER BUSINESS** **7.1 SCAN FOR SAFETY PROGRAM** IF gave the group an update on the scan for safety program which he has been working on for the last year. The scan for safety program is a national medical equipment management system that registers all medical equipment, asset registration, defect reporting, maintenance and maintenance records, and the recording of safety action notices. The objective was to have this in place by the end of the year but this now looks unlikely to happen. **7.2 NATIONAL SCAN FOR SAFETY LEADS** CF stated that there is to be a National scan for safety leads meeting on 31st August which she will be attending on behalf of Gemma Couser and will feedback any information to the group at the next meeting. Date of next meeting is **Thursday 8th December 2022 at 14:00** hrs via MS Teams	CF

Population Health and Wellbeing Portfolio Board (Meeting on 15 September 2022)
No issues were raised for escalation to the Clinical Governance Committee.

Population Health and Wellbeing Portfolio Board

MINUTE OF THE PORTFOLIO BOARD MEETING HELD ON 15 SEPTEMBER 2022 AT 10.00AM TO 11.00AM IN THE MAIN HALL, LYNEBANK HOSPITAL

Carol Potter
Chair

Present

Carol Potter (CP)	Chief Executive (Chairperson)
Dr Chris McKenna (CMcK)	Medical Director
Susan Fraser (SF)	Associate Director of Planning and Performance
Kirsty MacGregor (KMcG)	Associate Director of Communications
Linda Douglas (LD)	Director of Workforce
Joy Tomlinson (JT)	Director of Public Health
Nicky Connor (NC)	Director of Health and Social Care
Gillian MacIntosh (GMcI)	Head of Corporate Governance & Board Secretary
Margo McGurk (MMcG)	Director of Finance and Strategy and Deputy Chief Executive (deputy chair)
Alistair Graham (AG)	Associate Director of Digital and Information
Neil McCormick (NMcC)	Director of Property & Asset Management
Ben Johnston (BJ)	Head of Capital Planning and Project Director
Ben Hannan (BH)	Director of Pharmacy & Medicines
Mark McGeachie (MMcGe)	Charity Director

In Attendance

Claire Berry (CB)	Project Support Officer (Minutes)
Fiona McLaren (FMcL)	Head of PMO, Corporate PMO
Nicola Robertson (NR)	Associate Director of Nursing

Apologies

Claire Dobson (CD)	Director of Acute Services
Jeanette Owens (JO)	Director of Nursing
Tom McCarthy (TMcC)	Portfolio Manager, Corporate PMO
Wilma Brown (WB)	Employee Director

1.	**Unconfirmed Minute from meeting held 9 June 2022**
	The Minute from 14 July 2022 was accepted as an accurate record.
1.2	**Actions Outstanding**
	Action 25 - NHS Fife contribution to improving population health & reducing inequalities – Extended Acute SLT session to take place in September to discuss this agenda item and to get input from management team and clinical leads.
2.	**Programme Updates**
2.1	**Digital Tools** (Presentation attached)

	AG presented on Digital First and how this will support recovery of services by utilising the systems we have in a more meaningful way throughout each stage of the Digital First Model. This will include providing unlimited user access to systems which will allow for better planning and shared care and support across all services. **Action: CB to share Digital Tools presentation.**
2.2	**Population Health & Wellbeing Strategy Update**
	2.2.1 Report on Outcomes of Clinical Strategy
	SF presented on the changes since the publication of The Clinical Strategy 2016-2021 focusing on the 7 workstream recommendations and applying them to the 4 strategic priorities below: • Improve health and wellbeing • Improve quality and care of services • Improve health and wellbeing • Improve value and sustainability The Board acknowledged that looking back at the previous clinical strategy will help us to meaningfully look forward as we work to develop our new population health and wellbeing strategy. The fuller report will be shared with members once finalised.
	2.2.2 Focussed Community Engagement Plan
	SF provided the paper presented to EDG in August for information. Recruitment of the focus groups is ongoing and should be completed in 3 weeks.
	2.2.3 4 National Care Programmes
	SF provided the paper presented to EDG in August for information.
2.3	**Developing Personas**
	It was agreed at July Portfolio Board to take forward additional work to discuss personas and how they may usefully be used going forward. JT presented the Persona Development paper by Rishma Maini who has recently joined NHS Fife as Public Health Consultant. Rishma met with MMcG, JT and Fay Richmond to discuss work that has been done. JT highlighted that we must be careful in the way that we describe all the different elements in the population. Personas will be narrative in format rather than visual, including the disclaimer that they do not intend to be representative of a specific group. All relevant permissions to use lived experience stories will be sought prior to approving the final personas. <u>Proposed application:</u> Members of the public health team will work closely with the NHS Fife Population Health and Wellbeing Strategy team to identify narratives which reflect key findings and themes from the Director of Public Health Annual Report and align with strategic

	priorities. Appendix 2 provides an example case study which may be used. It is anticipated that at least six personas and will be identified and will serve two purposes: 1. Serve as a tool to engage stakeholders in sharing their views on how services may better meet the needs of the population. This could include using them to stimulate discussions with clinical staff as well as the public during focus groups being held in localities. 2. Potentially serve as illustrative examples which bring to life key messages within the final NHS Fife Population Health and Wellbeing strategy. JT will meet with Rishma to feedback all comments received from Portfolio Board. CP advised that there was a slide shared during Future Planning for NHS Scotland as a whole presentation that might be helpful. **Action: CP to circulate slide from Future Planning for NHS Scotland presentation.**
2.4	**Mental Health Inpatients Redesign Project**
	CMcK discussed the paper which was brought for approval which to agree that the Mental Health Impatient Redesign Project broaden its scope to consider all mental health services. The scope for the project is significant and includes estate held within NHS Fife, Fife Council and 3rd Sector Organisations. There is a lot of work to be done around what goes into the community hubs and what is needed from a capital and revenue point of view. NMcC highlighted that a programme initial agreement will be required to bring all the business cases together. NHS Fife would be one of the first boards to do this if successful. Terms of reference and workstreams will be updated. Final consultation has taken place and outcomes are awaited. The Board agreed to the proposal.
2.5	**Integrated Planned Care Programme**
	CMcK asked for feedback on allocations for Orthopaedics, NTC Fife. NHS Fife waiting times was highlighted and how this can be balanced if we are being allocated patients from other Boards. CMcK highlighted Repatriation of Robotic Prostatectomy to Fife. NHS Lothian have not progressed this service. NHS Fife are in the process of bringing some patients from Lothian to Fife. **Action: CD to provide feedback on the above points on return from annual leave.**
2.6	**Integrated Unscheduled Care Programme**
	CMcK highlighted that the RAG status is amber across all projects but there is evidence that things are happening but what does this mean in terms of outcome

	when things are still difficult at the front door. CMcK added that there is not enough resource to do what we want to do on a sustainable basis as we are experiencing unprecedented demand. A lot is about public communication and public behaviour as well as how we get our pathways right. **Action: CP requested to meet with CD/NC/CMcK to discuss unscheduled care further.**
2.7	**Pharmacy & Medicines Programme**
	BH advised that SF has provided support in terms of programme structure to ensure Pharmacy are streamlining reporting. BH asked FMcL to review the risks from the Programme to ensure there is consistency across all the Programmes **Action: FMcL to review HRPM risks.**
2.8	**Financial Improvement & Sustainability Programme**
	No items raised for discussion.
2.9	**Kincardine & Lochgelly Business Cases** **Update on Scottish Government Capital Investment Group Meeting**
	JT advised that dialogue is continuing with NHS Assure with a meeting scheduled for 16 September 2022. The economic case for CIG is in progress along with full costings.
2.10	**Report on Initial Prioritisation & Phasing across all programmes *(from the strategy milestone plan)***
	SF provided the paper for information. **Action: CP requested that Anchor Institutions is moved to priority 1.**
3.	**For Information**
3.1	**Integrated Unscheduled Care Programme Board Terms of Reference**
	No items raised for discussion.
3.2	**Youth Employment & Employability**
	CP requested item to be added to October Portfolio Board agenda for discussion. **Action: LD to check if paper should go to APF and Public Health Committee.**
4.	**AOCB**
	No further business discussed.
5.	**DATE OF NEXT MEETING**
	Thursday 13 October 2022 9.30am to 11.00am via Microsoft® TEAMS

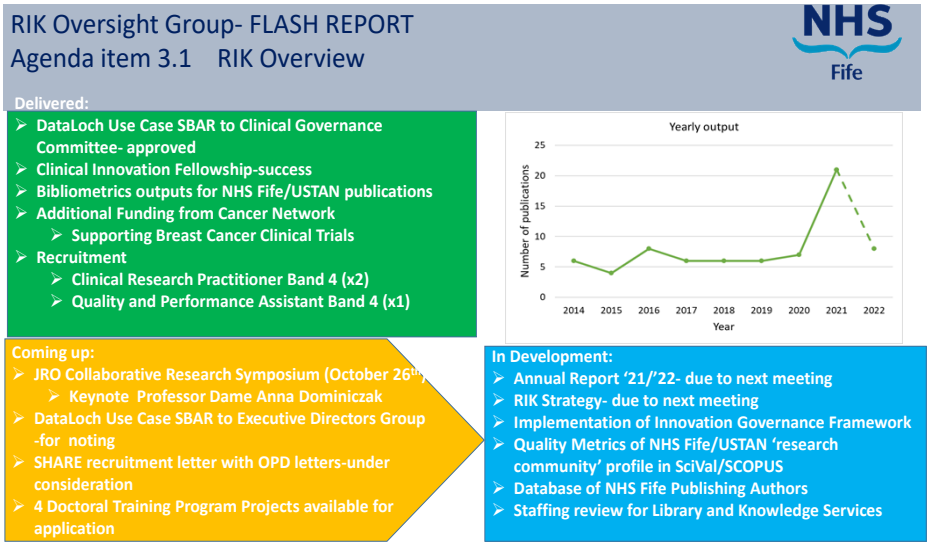
Research, Innovation & Knowledge Oversight Group

22 September 2022

No issues were raised for escalation to the Clinical Governance Committee.

RESEARCH, INNOVATION & KNOWLEDGE OVERSIGHT GROUP MEETING
MINUTES
Microsoft TEAMS,

	22 SEPTEMBER 2022 (2-3pm)	**ACTION**
	Present: Dr Chris McKenna, Medical Director, Executive Lead for Research, Innovation & Knowledge (CMcK) Prof. Frances Quirk, RIK Assistant Director (FQ) Dr Grant Syme, Physiotherapist Consultant (GS) Neil Mitchell, Innovation Manager (NM) Anne Haddow, Lay Advisor (AH) Gemma Couser, Associate Director of Quality & Clinical Governance (GC) Prof. Peter Donnelly, Chair In Public Health, University of St. Andrews (PD) Sally Tyson, Head of Pharmacy, Development & Innovation (ST) - representing Ben Hannan Doreen Young, Head of Practice & Professional Development (DY) – representing Nicola Robertson. Neil McNair, Lay Advisor (NMcN) - guest In Attendance: Roy Halliday, R&D Support Officer – minutes (RH)	
1.0	**CHAIRPERSON'S WELCOME/APOLOGIES AND OPENING REMARKS** **Apologies;** • Dr Joy Tomlinson, Director of Public Health • Nicky Connor, Director of Health and Social Care Partnership • Prof. Frank Sullivan, Director of Research, University of St. Andrews • Prof. Morwenna Wood, Director of Medical Education • Alistair Graham, Associate Director, Digital & Information • Prof. Colin McCowan, Head of Population and Behavioural Health Division, University of St. Andrews • Marie Paterson, Head of Nursing, Acute Services CMcK asked if the meeting was quorate. FQ noted that there was nothing on the agenda that needed approval. All attendees introduced themselves and described their roles to Neil McNair here today as an observer and who will be Anne Haddow's deputy for the Fife Community Advisory Council.	
2.0	**STANDING ITEMS**	
2.1	**OVERSIGHT OF R, I K OVERSIGHT GROUP MINUTE** The RIK Oversight Group Minutes were accepted with no amendments.	

	Action: the inclusion of SHARE recruitment letters with outpatient letters was discussed further, CMcK queried the need to use paper and whether there was an electronic option. FQ advised SHARE use their website , App and a QR code but metrics show much higher registration when hard copy invitations or in person recruitment. CMcK advised he would discuss further with FQ.	
2.2	**OVERSIGHT OF RIK OPERATIONAL GROUP MINUTE AND ACTION LIST** No items needed to be escalated to this Group but to note that there was positive engagement with the Scottish Cancer Research & Education Network around improving equity of access for Breast Cancer Studies and funding has been secured to recruit a Band 6 and Band 5 Nurse to focus on breast cancer study support and recruitment. R&D Clinical Research team support student nurse placement, one of our most recent students wrote an article about her positive experience in R&D which was published in the Nursing Times. The possibility of extending this opportunity to Medical Students has been discussed with the Medical Education team.	
3.0	**STRATEGIC PRIORITIES/INITIATIVES**	
3.1	**RESEARCH AND DEVELOPMENT** FQ stated that there were no specific R&D papers to be discussed at today's meeting and gave an overview of RIK activity since the last meeting.  FQ shared that NHS Fife have appointed the first Clinical Research Practitioner in Scotland, a role that enables people without a nursing qualification to become registered as a qualified Clinical Research Practitioner. Our Lead Nurse Karen Gray is also leading the development of national guidelines for Scotland for job descriptions and person specifications.	

	There will be an NHS Fife and University of St Andrews collaborative Research Symposium on 26th October, the keynote speaker will be the recently appointed Chief Scientific Officer Professor Dame Anna Dominiczak, currently there are 100 registered attendees and 30 confirmed presentations. FQ advised that the next step for the project with the Bibliometrics team at University of St Andrews was to generate quality metrics for separate and joint publication profiles for NHS Fife and St. Andrews University. A database of NHS Fife publishing authors is being developed by the Library and Knowledge Services team. CMcK noted the thorough update and liked the format.	
4.0	**RESEARCH AND DEVELOPMENT**	
4.1	**STUDY ARCHIVING** FQ advised that as a requirement, both contractual and legislative, we are required to retain hard copy study materials (trial master files, participant consent documentation, clinical research files) We lost our space for archiving when the Education Centre was being redeveloped. The boxes (100+) are currently stored in offices within the R&D Department, this is taking up usable space and is potentially a fire risk. Discussions with Records Management and Estates raised the possibility of storage at both Lynebank and Stratheden Hospitals but these have been deemed unsuitable. Discussions have been ongoing since July 2021. An approach has been made by Records Management to Fife Cultural Trust to ask if they would have space, an outcome is awaited. CMcK advised that he had not heard about this before this meeting and asked where it had gone previously in terms of escalation? FQ noted it has been raised in our Operational group and discussions with the Records Management team, Estates have also been included with discussions with the Records Management team but they have been unable to provide a solution. If Fife Cultural Trust is unable to archive these materials, we would need to store externally and pay for archiving, this had been discussed with Records Management previously and it was not their preferred option as a resolution. CMcK advised raising this with Alistair Graham re: Data Records Management and Estates.	**FQ/AG**
5.0	**INNOVATION**	
5.1	**INNOVATION UPDATE**	

NM updated the group from the Innovation Update Flash Report.
NM discussed the SHIP drug deaths consortium, chaired by Professor Alex Baldacchino and NHS Fife representation comes from our Clinical Innovation Champion, Dr Susanna Galea-Singer along with FQ. The Consortium is developing an Open Innovation challenge for solutions to reduce drug deaths, including prevention, earlier identification and intervention. Initial budget was £500,000 of funding from the Scottish Government but an additional £4.5 million has been secured from the Office of Life Sciences. SHIP and the Office of Life Sciences are currently working together to determine the governance of the challenge, NHS Fife are in a good position to potentially lead on this challenge.

NM also advised that within the RIK strategy, there is an aim to develop an engagement and awareness strategy to promote innovation and increase the number of staff on the workforce who are engaged with innovation, hopefully leading to future projects.

CMcK thanked NM for the comprehensive overview. CMcK suggested this needed more publicity and we should think of different ways of communicating these projects.

CMcK congratulated FQ and NM for starting to shape Innovation in Fife and the Flash Report identifies all the good work being done. **NM**

5.2 **CLINICAL INNOVATION FELLOWSHIPS**

NM drew attendees attention to the paper explaining the background of the Fellowships and the three Fellows within the Southeast region. NM noted that the next round of Fellowships should be coming in the next few months and this would be advertised once available.
FQ noted that the Clinical Innovation Fellowship was the third successful Fellowship this year, across three different programs, an NRS Career Researcher Fellow (Adeel Akhtar), a Multimorbidity Doctoral Training Programme Fellow (Sarah Bowers) and the Clinical Innovation Fellowship (Joyce Henderson). FQ added that this success demonstrates

	how RIK is supporting staff from different disciplines and at different stages of career. CMcK asked what the communications were around getting the Fellowships advertised. NM noted that we have an email distribution list and use Stafflink.	
6.0	**LIBRARY & KNOWLEDGE SERVICES**	
6.1	**LIBRARY STAFFING REVIEW** FQ discussed the upcoming changes in staffing within the Library Services with the upcoming retirement of Marie Smith who holds two positions as Library Services Manager and Librarian. The workload in the service is relatively high and there are two potential additional demands in the pipeline, firstly the Library and Knowledge Services support for the Right Decision Finder roll out and the other is the potential for additional medical students coming through in relation to the new Medical Program. This is an opportunity for us to review the service and how the service is resourced with some changes on the horizon. FQ and GC have had a preliminary conversation about the potential for ACT funding, CMcK advised this will be discussed further once FQ and GC have developed their discussion.	
7.0	**PARTNERSHIP UPDATES**	
7.1	**DOCTORAL TRAINING PROGRAMME** PD advised that this programme provided four year funding at a clinical level with six months run in, 3 three years PhD, six months post doctoral which is open to all the health professions. NHS Fife was successful with two Fellowships in the first round (projects focus on Public Health and Palliative Care) The second round has just closed. There are four projects open for application at St. Andrews; TB and HIV in East Africa, neurodevelopmental abnormalities, cancer screening and socially catastrophic falls and the elderly, those who are successful from the second round will commence in August of next year.	
7.2	**JOINT RESEARCH OFFICE** FQ discussed the output activity from the Bibliometrics team at St. Andrews Bibliometrics_20220 9-NHSFife-StA_short. FQ advised that the information within this presentation will inform some	

	of our planning and identifying topic clusters and areas of work going forward. The next step will be the production and review of the quality metrics.	
7.3	**NHS FIFE & UNIVERSITY OF ST. ANDREWS PARTNERSHIP** GC advised that since the last meeting there has been agreement with University of Saint Andrews colleagues that we will establish a Partnership Committee, which will provide an Executive level forum for overseeing the delivery of an evolving partnership across the domains of RIK and Medical Education and joint appointments. This would commence with a workshop event where both Institutions can come together and consider our shared purpose, common goals and vision for this partnership, which would then help to inform the Memorandum of Understanding.	
7.4	**R&D/FIFE COMMUNITY ADVISORY GROUP**. AH updated from her report (attached to the Agenda) advising that there have been no face-to-face meetings of the FCAC since the last report in June. However, members continue to meet virtually to discuss ongoing projects. Following one such meeting on the 8th July, Neil McNair kindly agreed to act as deputy at these meetings. Council members have also been invited to attend the Inaugural Collaborative Research and Innovation Symposium on the 26th October 2022 at Balgeddie House Hotel, Glenrothes.	
7.0	**AOCB** CMcK requested that we aim to make the next meeting on 14th December face to face. FQ reminded all regarding registration and attendance at the Inaugural NHS Fife / St. Andrews Collaborative Symposium on the 26th of October, advising an agenda will be issued shortly. FQ requested that all ensure that their teams were aware and encourage people to register and attend on the day.	
8.0	**DATE AND TIME OF NEXT MEETING** Wednesday 14th December , 11.00 – 12.00	

NHS Fife Resilience Forum

NHS FIFE RESILIENCE FORUM

(Meeting on Thursday 25 August 2022)

No issues were raised for escalation to the Clinical Governance Committee.

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

Minute of the NHS Fife Resilience Forum held on Thursday 25 August 2022 at 2.30pm via Microsoft Teams

Joy Tomlinson, Director of Public Health **JT**
Chair

Present:

Donna Baillie, Resilience Manager, Scottish Ambulance Service	**DB**
Paul Bishop, Head of Estates	**PB**
Kathleen Bolton, Digital Resilience Manager	**KB**
George Brown, Emergency Planning Officer	**GB**
Susan Cameron, Head of Resilience	**SC**
Hazel Close, Lead Pharmacist Public Health & Community Pharmacy	**HC**
Maggie Currer, A&E Consultant	**MC**
Kevin Irving, Architecture Resilience Manager	**KI**
Lorraine King, Business Manager	**LK**
Andrew MacKay, Deputy Chief Operating Officer	**AM**
Brian McKenna, Workforce Planning and Workforce Systems Lead	**BM**
Nicola Robertson, Associate Director of Nursing	**NR**
Allan Young, Head of Digital Operations	**AY**
Cali Ritchie, Personal Secretary (minutes)	**CR**

1. Welcome and Introductions
JT welcomed everyone to the meeting and introductions took place.

2. Apologies
Apologies were received from Wilma Brown, Linda Douglas, Susan Fraser, Kirsty MacGregor, Janette Owens and Kevin Reith.

3. Minutes of Previous Meeting (15 June 2022)
It was agreed the note of the previous meeting was an accurate record of the meeting.

3.1 Action Tracker
The action tracker was reviewed and updated on screen.

4. Matters Arising
4.1 Debrief Road Traffic Accident & VIE Victoria Hospital
SC advised that a debrief has been organised for this incident on 02 September 2022 at 1.00pm. Feedback will be shared with the group once received.

5. Terms of Reference
The Terms of Reference were agreed as a formal ratified version pending the following update:

Section 5 Standards 7 and 8; the owners should be adjusted to include HSCP Director.

6. Resilience Governance & Assurance
6.1 Quarter 2 Resilience Assurance/BCP Update
SC shared the quarter 2 report on screen and is happy to take feedback after meeting.

6.2 H&SCP - Persons at Risk Distribution Lists NHS Fife
No update given. Item to be carried forward to next meeting.

6.3 Planning & Performance
No update given. Item to be carried forward to next meeting.

6.4 Multi Agency Partnership (SAS, Police, F&R, EoS RRP) Significant Local Infrastructure - return for EOSRRP
SC had feedback from digital colleagues in relation to digital resilience and digital assets that we have critical exchanges we need to take into consideration. PB confirmed that he would send the estates return to SC for forwarding to EoS RRP by 01 September 2022.

7. Items for escalation to Scottish Government

7.1 EPRR Health Gov Scot Sit Rep Returns
SC advised that we require to submit a sit rep for any internal and external incidents that we have to Scottish Government to make them aware. A discussion ensued around the trigger points for this and category 1 response due to the OPEL situation and pressures in the hospital. It was agreed that SC will collate a sit rep report in the event of an incident requiring notification and ensure the lead for the area has sight of the sit rep prior to submission.

7.2 Digital Sit Rep - Cyber Incident 05/08/22
AY shared a presentation on screen describing a significant cyber attack. AY will provide an update at the next meeting on the lessons learned from this.

8. Emergency Plans

8.1 Major Incident Plans & Action Cards
GB/SC/CR had to briefly leave the meeting during this item due to a fire drill at Cameron House.
These were circulated with the meeting papers.GB asked for feedback on the action cards by 30 September 2022. It was agreed to ratify the Major Incident Plans for 2 years and review the action cards on a biannual basis.

8.2 Digital Risk; for major incident call out
JT highlighted that our phone system is reliant on digital connectivity and if we have a prolonged power outage and concurrent risk with a major incident call out, we would have a problem because there is no alternative available. There is a linked risk which is owned by Digital & Information and is assessed as low risk overall. To be discussed at the next meeting.

8.3 Severe Weather Framework Draft
GB asked for feedback by 25 September 2022. JT advised that KM had asked previously asked that the severe weather plan should be linked with the Communication Plan for Severe Weather. SC asked for feedback from digital colleagues on any potential disruption as a result of solar flares.

9. Training & Exercising

9.1 SAS SORT – 10 & 17 August / HAZMAT Scenario
DB provided an update whereby two teams have carried out decontamination type incidents, the difference between CBRN and HAZMAT and what SAS would be doing at the incident site regarding decontamination. MC advised that more sessions would be useful and DB agreed to pick this up with MC outwith the meeting.

10. Upcoming Significant Events
Fife Fest music festival on 10 & 11 September at Silverburn, Leven.

Multi agency incident scenario in October with NHS Lothian colleagues. Further details on this are awaited.

11. Any other business
Nothing to note.

12. Date of next meeting
24 November 2022 at 10.00am via Microsoft Teams.