NHS Fife Finance, Performance & Resources Committee

Tue 12 July 2022, 09:30 - 12:00

MS Teams

Agenda

09:30 - 09:30
0 min

1. Apologies for Absence

Verbal *Alistair Morris*

09:30 - 09:30
0 min

2. Declaration of Members' Interests

Verbal *Alistair Morris*

09:30 - 09:30
0 min

3. Minutes of Previous Meeting held on Tuesday 10 May 2022

Enclosed *Alistair Morris*

Item 03 - Finance, Performance & Resources Committee Minutes (unconfirmed) 10 May 2022.pdf (8 pages)

09:30 - 09:40
10 min

4. Matters Arising / Action List

Enclosed *Alistair Morris*

Item 04 - Finance, Performance & Resources Committee Action List - 12 July 2022.pdf (1 pages)

09:40 - 10:15
35 min

5. GOVERNANCE MATTERS

5.1. Annual Internal Audit Report 2021/22

Enclosed *Margo Mcgurk*

Item 05.1 - SBAR Annual Internal Audit Report 2021-22.pdf (4 pages)
Item 05.1 - Appendix 1 Annual Internal Audit Report 2021-22.pdf (41 pages)

5.2. Board Assurance Framework – Financial Sustainability

Enclosed *Margo Mcgurk*

Item 05.2 - SBAR Board Assurance Framework – Financial Sustainability.pdf (4 pages)
Item 05.2 - Appendix 1 Board Assurance Framework - Financial Sustainability.pdf (1 pages)
Item 05.2 - Appendix 2 Financial Sustainability Linked Operational Risks.pdf (1 pages)

5.3. Board Assurance Framework – Strategic Planning

Enclosed *Margo Mcgurk*

Item 05.3 - SBAR Board Assurance Framework – Strategic Planning .pdf (3 pages)
Item 05.3 - Appendix 1 Board Assurance Framework – Strategic Planning.pdf (1 pages)

5.4. Board Assurance Framework – Environmental Sustainability

Enclosed *Neil McCormick*

- Item 05.4 - SBAR Board Assurance Framework – Environmental Sustainability.pdf (3 pages)
- Item 05.4 - Appendix 1 Board Assurance Framework - Environmental Sustainability.pdf (1 pages)
- Item 05.4 - Appendix 2 Environmental Sustainability Linked Operational Risks.pdf (1 pages)

10:15 - 10:35
20 min

6. STRATEGY / PLANNING

6.1. Property & Asset Management Strategy (PAMS) 2021/22

Enclosed *Neil McCormick*

- Item 06.1 - SBAR Property & Asset Management Strategy 2021-22.pdf (3 pages)

6.2. Fife Capital Investment Group Reports 2022/23

Enclosed *Margo McGurk / Neil McCormick*

- Item 06.2 - SBAR Fife Capital Investment Group Reports 2022-23 .pdf (4 pages)

10:35 - 11:15
40 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report

Enclosed *Exec. Leads*

- Item 07.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
- Item 07.1 - Appendix 1 Integrated Performance & Quality Report.pdf (43 pages)

7.2. Integrated Performance & Quality Report Review Update

Enclosed *Susan Fraser*

- Item 07.2 - SBAR Integrated Performance & Quality Report Review Update.pdf (8 pages)

7.3. Labs Managed Service Contract (MSC) Performance Report

Enclosed *Claire Dobson*

- Item 07.3 - SBAR Labs Managed Service Contract (MSC) Performance Report.pdf (4 pages)
- Item 07.3 - Appendix 1 Audit Report B29-19.pdf (14 pages)
- Item 07.3 - Appendix 2 MSC Business Review Q4.pdf (42 pages)
- Item 07.3 - Appendix 3 Risk Assessment.pdf (4 pages)

7.4. Financial Improvement and Sustainability Programme Progress Report

Enclosed *Margo Mcgurk*

- Item 07.4 - SBAR Financial Improvement and Sustainability Programme Progress Report.pdf (7 pages)

11:15 - 11:20
5 min

8. FOR ASSURANCE

8.1. Delivery of Annual Workplan

Enclosed *Margo Mcgurk*

- Item 08.1 - Delivery of Annual Workplan.pdf (4 pages)

8.2. Procurement Governance Board Report No. B18-22

Enclosed

Item 08.2 - Procurement Governance Board Report No. B18-22.pdf (14 pages)

8.3. Financial Process Compliance Report No. B20-22

Enclosed

Item 08.3 - Financial Process Compliance Report No. B20-22.pdf (8 pages)

11:20 - 11:25
5 min

9. LINKED COMMITTEE MINUTES

9.1. Fife Capital Investment Group held on 20 April 2022 (unconfirmed)

Enclosed

Item 09.1 - Fife Capital Investment Group Minutes held on 20 April 2022 (unconfirmed).pdf (5 pages)

9.2. IJB Finance & Performance Committee held on 11 March 2022 (confirmed) and 29 April 2022 (unconfirmed)

Enclosed

Item 09.2 - IJB Finance & Performance Committee Minutes held on 11 March 2022 (confirmed).pdf (7 pages)
Item 09.2 - IJB Finance & Performance Committee held on 29 April 2022 (unconfirmed).pdf (4 pages)

9.3. Pharmacy Practice Committee held on 30 May 2022 (unconfirmed)

Enclosed

Item 09.3 - Pharmacy Practice Committee Minutes held on 30 May 2022.pdf (27 pages)
Item 09.3 - PPC Report - Appendix 1.pdf (10 pages)
Item 09.3 - PPC Report - Appendix 2.pdf (4 pages)
Item 09.3 - PPC Report - Appendix 3.pdf (5 pages)
Item 09.3 - PPC Report - Appendix 4.pdf (4 pages)
Item 09.3 - PPC Report - Appendix 5.pdf (2 pages)

11:25 - 11:30
5 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

10.1. To the Board in the IPQR Summary

Verbal *Alistair Morris*

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

Verbal *Alistair Morris*

11:30 - 11:30
0 min

11. ANY OTHER BUSINESS

11:30 - 11:30
0 min

12. Date of Next Meeting: Tuesday 13 September 2022 at 9.30am via MS Teams

MINUTE OF THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON TUESDAY 10 MAY 2022 AT 09:30AM VIA MS TEAMS

RONA LAING
Chair

Present:

R Laing, Non-Executive Director (Chair)
W Brown, Non-Executive Stakeholder Member
A Grant, Non-Executive Director
A Lawrie, Area Clinical Forum Representative
M Mahmood, Non-Executive Director
M McGurk, Director of Finance & Strategy
A Morris, Non-Executive Director
J Owens, Director of Nursing
C Potter, Chief Executive

In Attendance:

N Connor, Director of Health & Social Care
C Dobson, Director of Acute Services
S Fraser, Associate Director of Planning & Performance
B Johnston, Head of Capital Planning & Project Director *(agenda item 6.4 only)*
N McCormick, Director of Property & Asset Management
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M Michie, Deputy Director of Finance
B Hannan, Director of Pharmacy & Medicines
P Cumming, Risk Manager *(agenda item 5.5 only)*
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to meeting. Members were advised that a recording pen will be in use at the meeting to aid production of the minutes.

The Chair acknowledged the ongoing pressures with services and staff and noted that the organisation is no longer operating under direction of the Scottish Government. It was advised that there has been little change since the restrictions ended in terms of the enormous pressure on services and the impact that is having on our service performance.

It was noted this is the last meeting for R Laing, who is retiring from the Board at the end of May. The Committee warmly thanked R Laing for her service and contribution to the Board and wished her all the very best for the future. A Morris has agreed to take up the position of Chair going forward.

1. Apologies for Absence

Apologies were received from members Dr C McKenna, Medical Director, and Dr J Tomlinson, Director of Public Health.

2. Declaration of Members' Interests

The Chair made a declaration of interest on item 6.4 Kincardine & Lochgelly Health Centres Business Cases, and advised she is presently a patient at Lochgelly Health Centre.

3. Minute of the last Meeting held on 15 March 2022

The Committee formally **approved** the minute of the last meeting.

4. Action List / Matters Arising

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

5 GOVERNANCE MATTERS

5.1 Finance, Performance & Resources Committee Annual Statement of Assurance 2021/2022

The Head of Corporate Governance & Board Secretary advised that the Committee Annual Statement of Assurances are issued to the Audit & Risk Committee and the Board on a yearly basis to demonstrate that the Committees, via its various meetings, has addressed all aspects of the remit. A Morris, Non-Executive Member, agreed the report has the right level of detail to provide appropriate assurance on the items covered by the Committee in the past year.

The Committee **approved** the paper, for final sign-off by the Committee Chair and submission to the Audit & Risk Committee.

5.2 Board Assurance Framework (BAF) – Financial Sustainability

The Director of Finance & Strategy advised that the version of the BAF presented to the Committee will be replaced with a new corporate risk register from June 2022.

The BAF reflects the year-end financial position as of 31 March 2022, subject to external audit of the financial statements in July 2022.

It was reported that the moderate risk score reflects the in-year financial position. The creation of an additional corporate level finance risk which describes the level of risk on securing financial sustainability over the more medium-term is being progressed for the new corporate risk register.

The Committee took **assurance** from the content of the Board Assurance Framework.

5.3 Board Assurance Framework – Strategic Planning

The Director of Finance & Strategy advised that the BAF reflects the year-end position, and the risk level remains at moderate. It was highlighted that this risk is expected to

reduce as we progress through the milestone plan activity in terms of the strategy development.

It was reported all the Directorates are reviewing content within the existing BAFs in advance of transitioning to the new corporate risk register.

The creation of an additional corporate level risk in this area which describes the level of risk associated with the successful implementation of an impactful new strategy is being progressed for the new corporate risk register.

The Committee took **assurance** from the content of the BAF and **approved** the current position in relation to the Strategic Planning risk of Moderate.

5.4 Board Assurance Framework – Environmental Sustainability

The Director of Property & Asset reported that the environmental sustainability risk remains high and will remain so until the commissioning of the new Fife Orthopaedic Elective Centre completes by the end of 2022.

The recommendations identified within the Internal Audit Internal Control Evaluation in terms of delivery of the Property & Asset Management Strategy (PAMS) and capital programme will remain on the corporate risk register until it can be demonstrated that the risks have been appropriately mitigated through delivery of the new Fife Orthopaedic Elective Centre.

The Committee took **assurance** from the content of the Board Assurance Framework.

5.5 Risk Management Improvement Programme Progress Report

The Risk Manager joined the meeting to speak to the paper, in terms of the development of the strategic risk profile, it was reported that work is underway to include climate change and equality risks. Risks for inclusion within the corporate risk register are currently being identified with a view to concluding that work by the end of May 2022. It was reported a risk dashboard is under development and will become a feature of the IPQR going forward. It was also reported the escalation process is under review around risks and how those are managed.

The Director of Nursing informed the Committee that the process has been very positive, in terms of nursing, quality & control and governance.

The Chair requested more detail on governance and asked if the dashboard will be presented to each Board Committee. In response, it was advised that the risks within the corporate risk register will be assigned and be specific to each Committee. It was advised the IPQR will include all the risk management information from each Committee. It was also advised the positive aspects of the Board Assurance Framework will be retained and some of the more extraneous information that does not necessarily support understanding will be removed.

The Chief Executive added that the work that has been carried out has been very positive and reported that a meaningful assessment of our risks and how it connects overall to all the work that we do will be presented to Committees going forward, which will provide greater assurance.

The Risk Manager and team were thanked for all their hard work.

The Committee took **assurance** from this update on the plan to refresh and improve the Risk Management Framework.

5.6 Review of General Policies & Procedures

The Head of Corporate Governance & Board Secretary introduced the report which is presented to the committee twice a year for assurance purposes.

It was reported that good progress has been made since the last report to the Committee. A General Policies and Procedures Guidelines Pack has been developed and a workplan established, which will enable a more proactive approach to reviewing policies & procedures. The Board Committee Support Officer noted that these documents will be available to staff through Stafflink in the coming weeks. It was advised that more work is required to reduce the backlog, particularly for procedures. The current pressures on staff were highlighted which has had an impact on progress in reducing the backlog.

A Morris, Non-Executive Director, suggested deadlines for completion for the outstanding policies & procedures. The Head of Corporate Governance & Board Secretary agreed and noted a discussion would be required on the escalation route internally in the first instance. It was also noted that some of the policies are part of the wider work that is ongoing, such as the Risk Management Improvement Programme.

It was reported an electronic system would have benefits across the organisation, and discussions are still underway on how this could be addressed.

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

5.7 Review of Annual Workplan

The Head of Corporate Governance & Board Secretary reported that the Annual Workplan will be provided to each meeting as a tracked version. It was advised that the tracked workplan would be for information and noting at future Committee meetings.

The Committee **approved** the annual workplan.

5.8 Committee Development Sessions Programme 2022/23

The Director of Finance & Strategy spoke to the paper.

A Morris, Non-Executive Member, requested a timetable for the development sessions, and it was advised that timings will be aligned to the milestone plan for strategy development. The Director of Finance & Strategy will take forward a suggested timetable, and this will brought be back to the next meeting incorporated into the annual workplan.

Action: Director of Finance & Strategy

The Committee reviewed and **approved** the proposed development session topics for 2022/23, recognising that this may iterate over the course of the year.

6 STRATEGY / PLANNING

6.1 Corporate Objectives 2022/2023

The Director of Finance & Strategy advised that the corporate objectives align with the strategic framework, and progress against those relevant to this Committee will appear as substantive items throughout the year.

The Chief Executive advised that the corporate objectives links together strategic priorities and the outputs from the Strategic Planning Resource Allocation (SPRA) process.

A Morris, Non-Executive Member, welcomed the clarity provided on the direction of the corporate objectives, which provides a better understanding on the delivery of outcomes that we want to achieve.

Discussion took place on communicating the corporate objectives to staff. It was reported that the corporate objectives have been developed through the SPRA process at Directorate level.

W Brown, Employee Director, emphasised that not all staff will be aware of what the corporate objectives are and the importance of them. It was advised that comms and staff engagement will be carefully considered and include clear and meaningful explanations to groups of staff and individuals. It was noted there is an opportunity at the next stage of the strategy development to present the corporate objectives aspects to the wider organisation and provide opportunities for staff input and discussion.

The Chief Executive thanked the Director of Finance & Strategy and the Director of Workforce, for the work in reaching the current position and noted that the corporate objectives have been discussed in detail with the Executive Directors' Group.

The Committee considered and **endorsed** the corporate objectives.

6.2 Fife Capital Investment Group Report 2022/2023

The Deputy Director of Finance highlighted the main points from the report.

The Committee took **assurance** from the Fife Capital Investment Group Report 2022/2023

6.3 Orthopaedic Elective Project

The Director of Nursing spoke to the paper.

Following a question from A Morris, Non-Executive Director, on recruitment for the new build, an update was provided, and it was noted that there are no issues at this time.

The Chief Executive noted that staff transferring to the new build will be supported with the transition. W Brown, Employee Director, noted that there may be issues with the transition of theatre staff, and the Director of Nursing advised that this will be considered during the recruitment process.

The Committee took **assurance** from the update on the Orthopaedic Elective Project.

6.4 Kincardine & Lochgelly Health Centres Business Cases

The Head of Capital Planning & Project Director spoke to the key points on the Kincardine & Lochgelly Health Centres Business Cases.

A Morris, Non-Executive Member, questioned the involvement with Forth Valley Health Board on the Kincardine Centre and was advised that the Health & Social Care Partnership are in discussions and engaging with Forth Valley Health Board as they will provide the General Practitioner (GP) services and that NHS Fife will provide all other services within the centre.

The Director of Property & Asset Management supported the business cases and noted that they align well with the primary care premises strategy work that is ongoing.

Following a question from the Chair on the action list in relation to the IT & digital elements of the project, it was advised that the buildings will be flexible to accommodate a range of IT initiatives. Discussions are ongoing with Digital & Information and the Health & Social Care Partnership, and a subcommittee has been formed with various stakeholders. It was reported that the IT & digital elements will be incorporated through the full business case process, and the action list will be updated accordingly.

The Committee **endorsed** the Business Cases and recommended for Board approval at the end of May 2022.

7 QUALITY / PERFORMANCE

7.1 Integrated Performance & Quality Report

Acute Services

The Director of Acute Services provided an update on operational performance which has experienced unprecedented levels of demand from an unscheduled care perspective. The operational performance does however benchmark favourably against other Health Boards in Scotland. A focus continues on clinical prioritisation and maintaining this current level of service in demanding circumstances.

Health & Social Care Partnership

The Director of Health & Social Care Partnership advised delayed discharge continues to be report to the Finance, Performance & Resources Committee, with the other targets now reported to the Public Health & Wellbeing Committee.

It was advised that this period of reporting reflects an incredibly challenging time with very high number of ward closures, community ward closures and care home closures which has had a significant impact on flow. Significant pressures in relation to workforce was also reported.

It was noted that the Health & Social Care Partnership and Acute Services teams are working closely together on the pressures being experienced. Assurance was provided that there has been a significant improvement in delays and total delays in Fife, which

is reflected in the national data. It was noted delays is a national challenge and remains a priority for NHS Fife.

Finance
The Deputy Director of Finance provided an update on the revenue expenditure and noted that in-year targets have been met and are now subject to external audit.

It was reported the final tranche of Covid monies was received in February 2022, unallocated funding from this allocation will be carried forward by the Integration Joint Board (IJB) in a reserve for 2022/23.

Following a question from the Chair on the Covid reserve, the Deputy Director of Finance advised discussions have commenced with the Chief Financial Officer (CFO) on appropriately earmarking for Health Board delegated costs against this reserve.

The Committee took **assurance** from the Integrated Performance & Quality Report

7.2 Progress of Annual Delivery Plan (RMP4) 2021/2022

The Associate Director of Planning & Performance provided an update on the progress of the Annual Delivery Plan (RMP4) for 2021/2022 and advised that the paper covers three related aspects: Update on the actions from the RMP4, Winter Review Document and Winter Monitoring Report.

The status of the actions from the Annual Delivery Plan were highlighted and it was noted that the majority of actions are on track, or the target has been met. Incomplete actions that have not been met will be carried forward into the annual delivery plan for 2022/23.

Guidance from the Scottish Government has been received for the 2022/23 Annual Delivery Plan (which will replace the RMP).

The Committee took **assurance** from:

- The progress of deliverables within Joint Remobilisation Plan 4 (RMP4)
- The lessons learned from Review of National Response to Winter 2021/22
- The performance in the Winter Report 2021/22 – Data to March 2022

8 LINKED COMMITTEE / GROUP MINUTES

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

8.1 Minute of Fife Capital Investment Group, dated 9 March 2022
8.2 Minute of Pharmacy Practice Committee, dated 18 March 2022

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

9.1 To the Board in the IPQR Summary

There were no issues to escalate to the Board in the IQPR summary.

9.2 Chair's comments on the Minutes / Any other matters for escalation to

NHS Fife Board

The Chair and Director of Finance & Strategy will discuss any issues to be escalate to the Board.

10. ANY OTHER BUSINESS

There was no other business.

11. DATE OF NEXT MEETING

The next meeting will be held on Tuesday 12 July 2022 at 9.30am via MS Teams.

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

FINANCE, PERFORMANCE & RESOURCES COMMITTEE – ACTION LIST

Meeting Date: Tuesday 12 July 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	10/05/22	**Committee Development Sessions Programme 2022/23**	A suggested timetable for the development sessions to be brought back to the next meeting incorporated into the annual workplan.	**MM**	12/07/22	Development Sessions set up for 21/09/22 and 25/01/23 and incorporated into the workplan.	Closed

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 July 2022**
Title:	**Annual Internal Audit Report 2021/22**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance
- Approval

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the **FINAL** 2021/22 Annual Internal Audit Report to the Committee. This report is for the Committee to consider as part of the wider portfolio of year end governance assurances.

2.2 Background

The Committee is asked to approve this report with completed action plan as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

This annual report provides details on the outcomes of the 2021/22 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2021/22.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2021/22 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

We noted the following key themes:

- The Board continues to respond positively to the governance challenges posed by Covid19. During 2021/22, NHS Fife has adapted its approach to governance when needed to ensure the organisation could effectively respond to Covid19 and discharge its governance responsibilities, maximising time available for staff to deal with Covid19.
- Operational performance in the face of the challenges posed by Covid has been difficult during the year and it is likely that the challenge will continue in the medium term until strategic solutions can be found, working in partnership with the IJB.
- As previously reported in the 2021/22 ICE report, during 2021/22 the necessary focus has been on the immediate priority of the response to Covid19 and on government mandated actions and performance. The challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, not all of which are known yet, but the Board has instigated the necessary preparatory work and a risk assessment to ensure the most urgent work is prioritised.
- Whilst the Board planned to update all strategies during 2021/22, this work was necessarily delayed due to Covid19. Updated timetables, detailing the roles and responsibilities of Standing Committees and the Board with key stages and targets documented will aid the progress needed to achieve the March 2023 completion date. Whilst the SGHSCD has set a number of very challenging national objectives, NHS Fife will need to be mindful that its own strategic objectives must be deliverable within acceptable risk tolerances.
- NHS Fife continues to progress its overhaul of its Risk Management Framework. Covid 19 risks will be considered as linked operational risks, corporate risks in their own right, or will be treated as business as usual as part of the Risk Management Framework development.

- This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now further to enhance governance through the further application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and agreed by the Director of Finance and Strategy.

2.4 Recommendation

The Committee is asked to:

- **APPROVE** this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

3 List of appendices

The following appendices are included with this report:

- Annual Internal Audit Report 2021/22

FTF Internal Audit Service

Annual Internal Audit Report 2021/22

Report No. B06/23

Issued To: Carol Potter, Chief Executive
Margo McGurk, Director of Finance and Strategy
NHS Fife Executive Directors Group

Gillian MacIntosh, Head of Corporate Governance and Board Secretary

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	2 June 2022
Management Responses Received	6 June 2022
Target Audit & Risk Committee Date	16 June 2022
Final Report Issued	**13 June 2022**

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit & Risk Committee provides details on the outcomes of the 2021/22 internal audit and my opinion on the Board's internal control framework for the financial year 2021/22.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2021/22 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

ACTION

4. The Audit & Risk Committee is asked to **take assurance from** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2021/22 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance & Strategy and were approved by both the Executive Directors Group (EDG) and the Audit & Risk Committee. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Appendix 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit & Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued December 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee, EDG and other papers. The ICE noted actions to enhance governance and achieve transformation and concluded that NHS Fife's assurance structures were adequate and effective. 12 recommendations were agreed for implementation by management.

9. The status of previous recommendations is summarised in the table on page 11. In addition, 3 recommendations from previous Internal Control Evaluations and Annual Reports remain in progress due to the ongoing impact of Covid:

   - Development of Population Health and Wellbeing Strategy.
   - Refinement of the Property Asset Management Strategy to support the Population Health and Wellbeing Strategy.
   - Development of Clinical and Care Governance Strategic Framework.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the ongoing impact of Covid19 on the governance arrangements in place during the year. Some areas for further development were identified and will be followed up in the 2022/23 ICE. Where applicable, our detailed findings have been included in the NHS Fife 2021/22 Governance Statement.

11. Our assessment of the progress to address ICE recommendations is detailed in the table on page 11. NHS Fife has demonstrated good progress with only minor slippage on the majority of actions, although clearly, the revision of the overall and supporting strategies will be a significant task and much work remains to be done. The 2022/23 ICE will provide an update on the remaining actions as well as providing an opinion on the efficacy of implementation of all agreed actions.

12. For 2021/22, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of IJBs.

13. The Board has produced a Governance Statement which states that:

    '*During the 2021/22 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control*'.

14. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2021/22, provides assurance for the Chief Executive as Accountable Officer.

15. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place;

- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, this process has been further enhanced by guidance written by the Director of Finance and Strategy. These assurances have been reviewed and no breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19. The Governance Statement includes details of the Board performance profile and risk management arrangements, and the future intention to revise organisational and supporting strategies. All elements of the Governance Statement have been considered by Internal Audit in previous internal audit annual reports and the ICE and have been followed up in detail in this report.

Key Themes

18. Detailed findings are shown later in the report. Key themes emerging from this review and other audit work during the year, as well as consideration of the overall impact of Covid19 and the need to ensure sustainable services, are detailed in the following paragraphs.

19. The Board continues to respond positively to the governance challenges posed by Covid19. During 2021/22, NHS Fife has adapted its approach to governance when needed to ensure the organisation could effectively respond to Covid19 and discharge its governance responsibilities, maximising time available for staff to deal with Covid19.

20. Operational performance in the face of the challenges posed by Covid has been difficult during the year and it is likely that the challenge will continue in the medium term until strategic solutions can be found, working in partnership with the IJB.

21. As previously reported in the 2021/22 ICE report, during 2021/22 the necessary focus has been on the immediate priority of the response to Covid19 and on government mandated actions and performance. The challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, not all of which are known yet, but the Board has instigated the necessary preparatory work and a risk assessment to ensure the most urgent work is prioritised.

22. Whilst the Board planned to update all strategies during 2021/22, this work was necessarily paused due to Covid19. Updated timetables, detailing the roles and responsibilities of Standing Committees and the Board with key stages and targets documented will aid the progress needed to achieve the March 2023 completion date. Whilst the SGHSCD has set a number of very challenging national objectives, NHS Fife will need to be mindful that its own strategic objectives must be deliverable within acceptable risk tolerances.

23. NHS Fife continues to progress its Risk Management Framework Improvement Programme. Covid 19 risks will be considered as linked operational risks, corporate risks in their own right, or will be treated as business as usual as part of the Risk Management Framework development.

24. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to further enhance governance through the application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

Key developments since the issue of the ICE included:

- The April 2022 NHS Fife Board Development session on Culture, Values and the Role of the Board and Developing our Population Health and Wellbeing Strategy.
- A Risk Management Framework Improvement Programme was approved by the NHS Fife Board in March 2022.
- The updated Fife IJB Integration Scheme was formally signed off by the Scottish Government on 8 March 2022.
- Progress against the 4th iteration of the Remobilisation Plan was reported to the May 2022 meeting of the Finance, Performance & Resources Committee (FPRC), with all incomplete action to be included in the 2022/23 Annual Delivery Plan.
- The development of the Operational Pressures Escalation Levels (OPEL) process to manage day-to-day pressures, with clear triggers for action and escalation.
- A review of the Integrated Performance and Quality Report (IPQR) content and format to address actions from the Board's Active Governance session and to ensure it remains relevant and clear to Board members.
- As of April 2022, NHS Scotland is no longer on emergency footing.

25. During 2021/22 we delivered 25 audit products (May 2021 to June 2022) with a further two products issued in draft. These audits reviewed the systems of financial and management control operating within the Board.

26. Our 2021/22 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

27. A number of our reports, including the ICE and Strategy development, have been wide ranging and complex audits and have relevance to a wide range of areas within NHS Fife. These reports continue to assist NHS Fife to build on the very good work already being done to improve and sustain service provision.

28. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Internal audit have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit & Risk Committee. As reported to the March 2022 Audit & Risk Committee, 37 audit actions were remaining, with 11 risk assessed as Amber – action required, 23 risk assessed as Green – good progress and 3 not yet due.

ADDED VALUE

29. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

- Examining a wide range of controls in place across the organisation.
- Undertaking Fife IJB internal audits and providing a Chief Internal Auditor Service.
- For the Fife Integrated Joint Board (IJB), updating and enhancing the IJB Governance Statement self assessment checklist.
- Providing initial comment on a draft version of the now approved Integration Scheme.

- CIA liaison with the Director of Finance & Strategy, on issues of governance, risk, control and assurance.
- Assurance mapping and risk management advice, in particular on Digital and Information risk reports.
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Assurance reporting regarding Whistle blowing (quarterly and annual).
- Commenting on Terms of Reference for the Quality Management Assurance Group.
- Facilitating the work of the Assurance Mapping group and liaising with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife.
- Highlighting national governance developments with relevance to NHS Fife.
- Continued development and use of the principles for Health & Social Care Integration (HSCI) governance and sustainability within the Board and its IJB partner.
- Detailed review of the process for revising NHS Fife's overall Strategy.
- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Contribution to the development of the NHS Fife Risk Management Strategy and Fife IJB Risk Management Framework.
- Advice provided to the Fraud Liaison Officer in response to an ongoing incident and attendance at meeting.

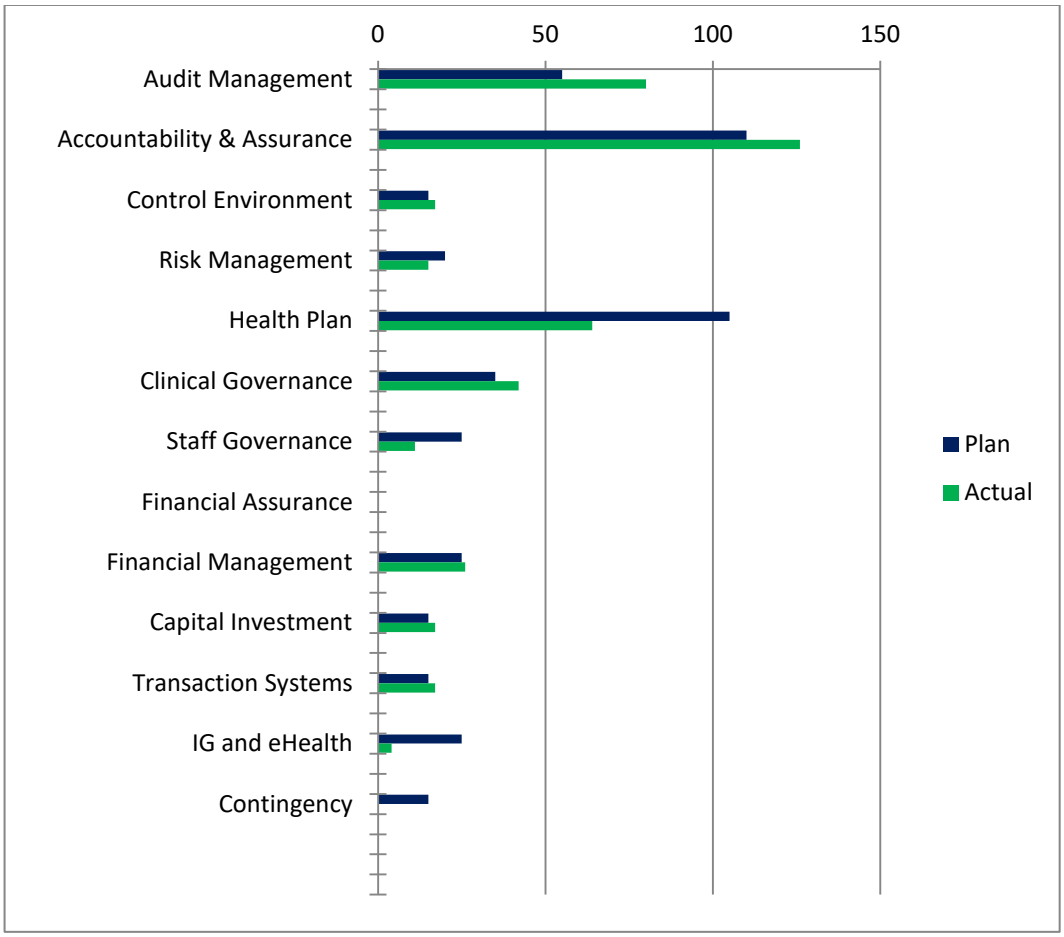
30. Internal Audit have also used time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

    - Update of the Committee Assurance Principles.
    - Development of a good practice template for the process of developing new Strategic Plans in IJBs and Health Boards.
    - Development of the FTF website.
    - Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.
    - Reviewed our recommendation priorities to include an additional category 'Moderate' and updated the assurance definitions.
    - Updated the Property Transaction Monitoring Checklist for FTF clients.

31. The 2021/22 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, and providing the Chief Internal Auditor function to Fife Integrated Joint Board as well as progressing the audit plan of Fife IJB agreed with the IJB. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk as well as the requirement for a revised Strategic Plan and working with partners to clear intractable and long-standing issues.

INTERNAL AUDIT COVERAGE

32. Figure 1: Internal Audit Cover 2021/22



33. Figure 1 summarises the 2021/22 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit & Risk Committee at its meeting on 13 May 2021. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit & Risk Committee approved amendments in March 2022. We have delivered 412 days against the 455 planned days.

34. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2021/22 audits for inclusion in the 2022/23 plan.

35. A summary of 2021/22 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

36. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2021/22. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2021/22 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

37. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

38. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance and Strategy rather than the Accountable Officer. There are no impairments to independence or objectivity.

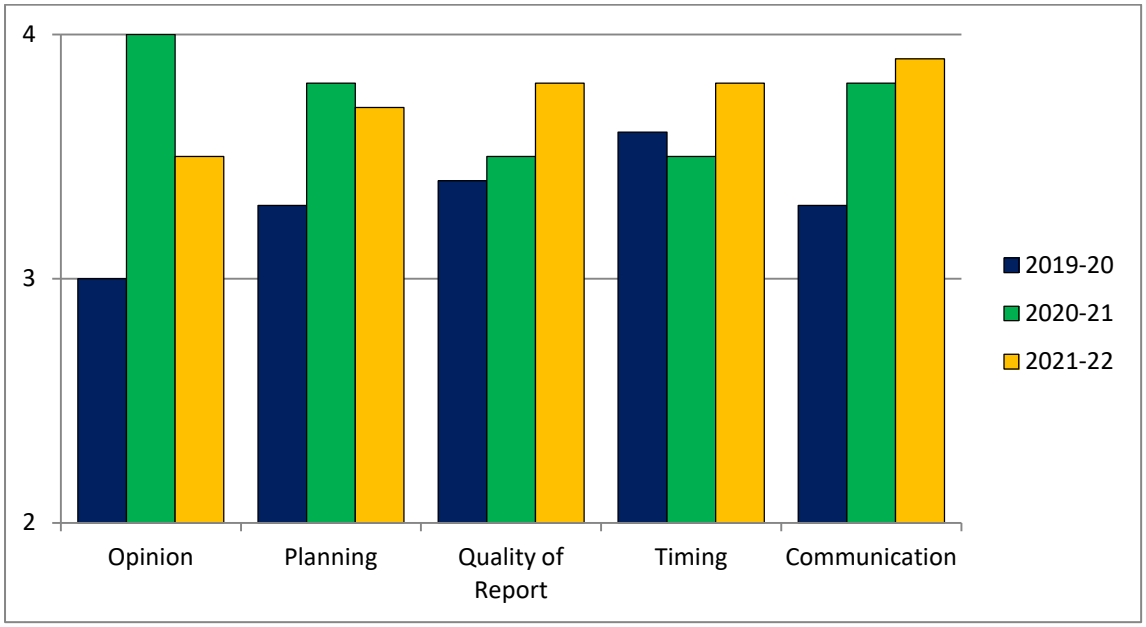
39. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

40. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Fife Internal Audit Service in 2018/19 concluded that, *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment which is due to presented to the June 2022 Audit & Risk Committee.

41. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

42. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



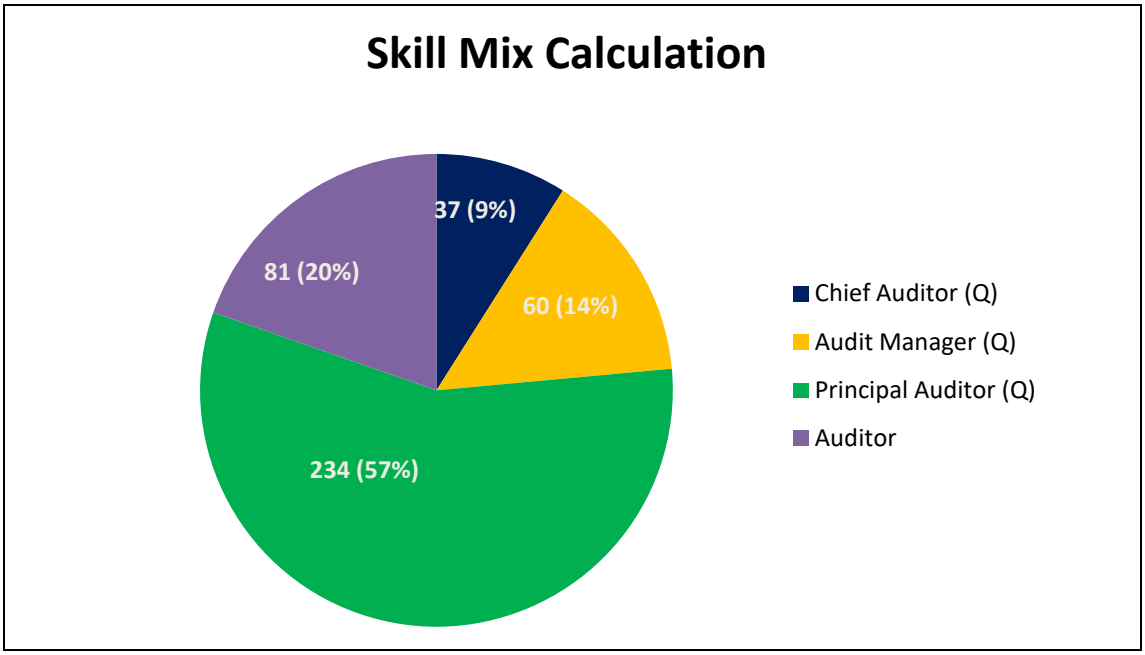
43. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

44. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2021/22 the audit was delivered with a skill mix of 81%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

45. **Figure 3: Audit Staff Skill Mix 2021/22**

Audit Staff Inputs in 2021/22[days] Q= qualified input.



ACKNOWLEDGEMENT

46. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

47. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance & Strategy, the Board Secretary, EDG and the Audit & Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

ICE 2021/22(B08/22) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Board Assurance Framework • The inclusion of appropriate analysis in each SBAR supporting the BAFs regarding the adequacy and effectiveness of key controls and actions would promote/aid further scrutiny by committee members. • The Board Assurance Framework should encompass and link Covid19 risks, to ensure the NHS Board has appropriate oversight and transparency over these risks. • Once the revised Integration Scheme has been approved by the Scottish Government, the IJB BAF should be revised to ensure that it adequately describes the risk the mitigating controls and appropriately scored. ***Action Owner: Chief Executive & Director of Finance*** ***Original date of expected completion for all of the above is the 31 March 2022.***	A detailed Risk Management Improvement Plan has been developed. It was agreed with the EDG in February 2022 and presented for assurance to each Standing Committee in May 2022. This sets out the further work required to complete and embed the changes required. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
2. Performance Reporting • As part of this Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls. • The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described. ***Action Owner:*** **Director of Finance and Strategy** ***Original date of expected completion for all of the above is the 31 March 2022.***	A detailed Improvement Plan has been developed and was agreed with EDG in February 2022 and the FPRC in March 2022. This sets out the further work required to complete and embed the changes required. Aspects of the plan have been completed. ***Date Expected Completed – 30 June 2022***	 **Minor slippage on agreed timelines**

3.Organisational Duty of Candour • An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to Clinical Governance Committee (CGC) prior to it concluding on its Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow it to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22. • The Committee should be informed when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The CGC considered the Interim 2020/21 NHS Fife Duty of Candour report at its 13 January 2022 meeting, and it was noted by Fife NHS Board at their meeting on 29 March 2022, although this related exclusively to Duty of Candour Activity that occurred in the financial year 2020/21. The CGC has not received any update on Duty of Candour Activity occurring in financial year 2021/22. The Medical Director advised that delays to the adverse event process in its entirety are a known consequence of the impact of the Covid-19 pandemic on service pressures. Recovery to a state where more timely reporting is heavily dependent on the recovery of the backlog of closure of adverse event reviews.	 **Significant Slippage**
4. Adverse Events KPIs • The revised approach for Adverse Events should include regular reporting of KPIs to CGC on the completion of adverse events within agreed timescales. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 30 April 2022.***	The Clinical Governance Oversight Group (CGOG) merged with the Adverse Events and Duty of Candour Group and its revised Terms of reference were presented to the CGOG meeting on 19 April 2022. These include the responsibility *'To oversee the development and implementation of local guidance relating to Adverse Events and Duty of Candour including monitoring of performance against agreed measures*'. For this action to be considered complete we need evidence of the new reporting arrangements to CGOG operating in practice and will report on this in the 2022/23 ICE report. The Medical Director advised that there is currently no plan, unless by escalation, to routinely report these KPI's with the CGC.	 **Minor slippage on agreed timelines**
5. Succession Planning • The Staff Governance Committee (SGC) and Remuneration Committee should be assured	Within the draft Workforce Plan 2022-25 there is a medium term action for	 On track

on succession planning arrangements within NHS Fife and of the potential risks associated with this area. ***Action Owner: Director of Workforce*** ***Original date of expected completion for all of the above is the 31 October 2022.***	Directorate level Workforce Plans, to consider succession planning implications for a range of critical roles, including advanced practitioners grades and above. This will give assurance to the SGC that succession planning is being considered, but the SGC and Remuneration Committee still require a full update on the implementation of these arrangements and the potential risks associated with this area.	
6. Staff Governance Standards • To enable the SGC to fully ascertain the SGS initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGS, the assurances given at those meetings should give an equivalent level of assurance to that of previous years (per the previously maintained SGAP), setting out actions and assurances still to be provided and the reasons for any delays. ***Action Owner: Director of workforce.*** ***Original date of expected completion for all of the above is the 31 March 2022.***	This recommendation has not been implemented as agreed. For 2021/22 only verbal updates on the action taken to meet the SGS has been provided at the September 2021 and March 2022 SGC meetings. No documented record has been provided of the initiatives introduced and the actions and assurances still to be provided and the reason for any delays. As part of its 2021/22 Annual Assurance Statement the Committee has agreed to "enhancing the signposting on papers and agenda items, to make it clear which strand of the Standards is being addressed, to ensure full coverage across the Committee's yearly workplan".	 **Significant Slippage**

7.IPQR and Financial Sustainability BAF • Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed. • The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations. ***Action Owner:*** **Director of Finance and Strategy** ***Original date of expected completion for all of the above is the 31 March 2022.***	An Improvement Plan has been developed and was agreed with EDG in February 2022 and the March 2022 FPRC. This sets out the further work required to complete and embed the changes required. Concluding this recommendation has clear links to the ongoing requirements of Risk Management Improvement Plan. The development of the Financial Improvement/Sustainability (FIS) Programme will support the delivery of efficiency savings and closing significant external audit recommendations. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
8. Property & Asset Management Strategy (PAMS) • The risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy. ***Action Owner: Director of Property and Asset Management*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The Environmental Sustainability BAF presented to the FPRC in May 2022 has committed to a new corporate risk related to the Capital Programme and Property Strategy to be developed within the revised Risk Management Framework. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
9. IG&S Assurance Reporting to CGC • Regular assurance reporting from the IG&SSG to CGC should be scheduled in the workplan of CGC for 2021/22 and future years. • This should include a regular Assurance Report as well as IG&SSG minutes. • The Assurance report should include clear, sufficient and reliable assurance on the key aspects of IG&S so that the CGC can conclude on the adequacy and effectiveness of Information Governance arrangements at year end. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the*** **28 April 2022**	Activity Tracker report provided IG&S assurance to CGC at their meeting on 10 March 2022 and updates are scheduled in the committee's 2022/23 workplan for September 2022 and March 2023.	 **Complete and Validated**

10. Information Governance and Security Policies • Assurance provided regarding Information Governance Policies and Procedures should be improved so that a list of all policies and procedures and their review dates is provided to the IG&S Operational Group and percentage compliance, regarding reviewed within scheduled review date, figures are reported to the IG&S Steering Group. • Progress towards mitigating the risk regarding lack of resources for Information Governance and Security Policy Management should also be reported to the IG&S Steering Group. • The NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] must be reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 14 February 2022**	The IG&S Key Measures Report to March 2022 IG&SSG includes an update on policies at section 5. Reporting on how the required level of resources was being provided was included in section 4.5 of the IG&SSG Annual Assurance Statement. Revised Information Security Policy (GP/I5) is published on Stafflink with a scheduled review date of January 2025. Although we are advised that the NHS Fife Data Protection and Confidentiality Policy [GP/D3] has been reviewed, and is being presented to the General Policies Group and EDG for approval, the version of the policy published on Stafflink is the old version which had a scheduled review date of 1 June 2021.	 **Minor slippage on agreed timelines**
11. Information Governance Incident Management • The assurance route for reporting of assurances on Information Governance incidents needs to be clarified and streamlined to provide sufficient assurance to CGC. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 31 March 2022**	Section 6.1 of the IG&SSG Annual Assurance Report includes the recommended details regarding IG&S incidents. This was considered by IG&S Steering Group following cancellation of scheduled meeting on 8 April 2022 and then by CGC 29 April 2022.	 **Complete and Validated**
12. Digital and Information Risk Management • It is important that the processes for recording and managing risks related to Digital and Information are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions. • The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be	The risk reports presented to IG&SSG and Digital & Information Board have been updated in format throughout 2021/22 and a review of all risks was undertaken which included revisiting the scoring and considered the impact of the pandemic. The new format includes graphical representation to highlight risks with improved or deteriorating ratings and provides	 **Complete and Validated**

provided to CGC. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 31 May 2022**	detailed analysis on the highest ranked risks which provided the Group with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. To date the Group has been able to provide that assurance for the highest ranked risks.	
ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the Strategic Planning and Resource Allocation (SPRA) as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The recommendation was integrated with the plan to develop the new Population Health and Wellbeing Strategy. Progress was made during 2021/22 on a number of key stages however the ongoing impact of the pandemic has led to delays. A paper detailing the re-phasing of this work was approved by the Public Health and Wellbeing Committee on 8 March 2022 and the NHS Fife Board at the end of March. The paper includes a milestone plan to deliver the new strategy by the end of December 2022, with Board approval by the end of March 2023. The paper also sets out the Portfolio Board arrangements to support the development of the strategy work and the governance route for each activity as the plan is developed. ***Date Expected Completed – 31 March 2023***	**Pausing of development activities as a consequence of the pandemic.**  **Minor slippage on agreed timelines**
3. Clinical Governance Framework • Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration	Progress has slipped slightly from original targets to allow further engagement with staff which has been taking place taking place regarding a draft version of the NHS Fife Clinical and	 **Minor slippage on agreed timelines**

Principles. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 31 March 2022.***	Care Governance Strategic Framework 2022-2025. It has been agreed with the Chair of the CGC, the Medical Director and Nursing Director that the Framework will be presented to CGC for approval at their meeting on 1 July 2022. The Medical Director advised that due to unforeseen circumstances a further extension has been deemed necessary.	
5. Property Management Strategy • The Property Management Strategy should be reviewed and revised to align it to updated NHS Fife Strategies and future sustainability and should specifically consider the impact of Covid19 around the property infrastructure going forward. ***Action Owner: Director of Property and Asset Management*** ***Original date of expected completion for all of the above is the 30 August 2021***	The paper considered by Fife NHS Board on 29 March 2022 on the plan for the Population Health and Wellbeing Strategy included the further development of the PAMS strategy. ***Date Expected Completed – 30 November 2022***	 **Minor slippage on agreed timelines**
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group Terms of Reference (ToR) • Digital and Information (D&I) Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital*** ***Original date of expected completion for all of the above is the 30 April 2021***	IG&SSG and IG&SOG ToRs agreed and meetings taking place. Reporting through Activity Tracker to IG&S Steering Groups and to CGC: •To 4 March IG&SSG – Tracker & Performance •To 10 March CGC – SBAR & Tracker Board Assurance Framework for D&I Strategy Delivery reporting including linked risks provided to CGC via EDG (September 2021, November 2021, and March 2022). Risk Reports including performance analysis and detailed root cause analysis and risk proximity reported to D&I Board and IG&S Steering Group.	 **Complete and Validated**

Annual Report 2020/21 – B06/22		
1. Increased Risk of Harm • A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect: • The key priorities and aims for 2021/22 within the current remobilisation plan. • Other relevant controls, such as implementation of Royal College of Surgeons guidelines • A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates. • Identified requirements to redesign services. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 30 November 2021.***	The change to the Quality & Safety BAF was proposed and agreed by CGC at their meeting on 3 November 2021 and the was presented again to CGC at their meeting on 10 March 2022 and the revised risk description is reflected in the version of the BAF presented to CGC on 29 April 2022. The Quality and Safety BAF Risk description now reflects risk to patients from reprioritisation associated with the pandemic and linked risks include pandemic related risks.	 **Complete and Validated**

Corporate Governance

BAF risks:

Risk 1675 - Strategic Planning – Moderate (12)

- There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

Risk 1676 – Integration Joint Board –Moderate (12)

- There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.

Strategy

The ICE report highlighted positive progress on the plans to develop the Population and Wellbeing Strategy (PWS) and welcomed NHS Fife's intention to have an approved Strategy in place by 31 March 2022. This was delayed by the ongoing impact of Covid19; a revised timetable was approved by Standing Committees and the Board in March 2022. Consequently with a one year Transitional Strategic Plan will be submitted in line with the Scottish Government (SG) deadline of 31 July 2022. A one year financial plan for 2022/23 was approved by the Board and submitted to Scottish Government in March 2022.

The approved timetable details a route map for the development of the medium to long term Population Health and Wellbeing Strategy, with a draft Strategy and associated Delivery plan to be presented to the NHS Fife Board by December 2022. The route map provides key steps and dates, with dates established for Standing Committees and the Board to review and influence the work.

The SGHSCD issued the NHS Recovery plan on 25 August 2021. The recent Audit Scotland report NHS in Scotland 2021 stated that '*The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives. The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.*' The SGHSCD have subsequently issued further guidance reiterating its intention for NHS Boards to deliver the objectives within the NHS Recovery Plan. However, it is clear that the workforce and financial assumptions underlying both the NHS Recovery Plan and the Health and social care: national workforce strategy would require very careful risk assessment, before they could be relied upon in local planning.

Whilst the Board will need to be cognisant of SGHSCD ambitions, its priority must be the production of a realistic, achievable strategy which addresses the needs of the local population post-covid within the parameters of available resources, most particularly financial, digital and workforce. This will almost inevitably involve extremely difficult decisions, which may not fully align with public or SGHSCD expectations.

During the Covid pandemic, there was a necessary shift of focus towards operational priorities, which reflected the extreme risks in those areas as well as an influx of Covid related funding which lessened the immediate financial risk. In future, the risks related to financial sustainability are likely to rise sharply and rapidly, with the acute sector in particular facing very significant financial challenges. Consideration of the changes in culture required to adapt to this change should start now. The implementation of the Financial

Improvement and Sustainability Programme in November 2021 will be a key enabler to securing recurring financial balance and sustainability. In March 2022, the Finance, Performance & Resources Committee (FPRC) were provided an update on the Operational Pressures Escalation Levels (OPEL) process, which aims to manage day-to-day pressures, with clear triggers for action and escalation. We commend this development and note the Scottish Government interest in the overall tool. An update report on how the OPEL process is working in practice would be a useful future assurance report to the FPRC.

Covid19 & Governance

NHS Fife has continued to monitor and adapt arrangements to maintain an appropriate level of governance, whilst taking account of the pressures on management and the need to free operational staff to deal with Covid19.

On 20 May 2020 the Board ratified revised governance arrangements for the Board's Standing Committees whereby meetings were to be undertaken by TEAMs. The command structure which was stood down from 31 March 2021 was reinstated in July 2021 due to resurgence in Covid19 cases.

Given the lifting of Covid19 restrictions during April 2022, NHS Fife successfully tested its first face to face meeting for two years at a Board Development session in April 2022.

Covid19 reporting to Board has continued and covers: Covid19 Vaccination, Test and Protect and Covid19 Testing in Fife.

Assurance Mapping

The Chief Internal Auditor, working with officers from NHS Fife and other client Health Boards, developed a set of Committee Assurance principles, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them. These were considered and endorsed by the NHS Fife Audit & Risk Committee at its meeting in May 2021.

The Board Secretary is working with Standing Committee Chairs to ensure these are embedded within the Board's formal assurance processes and Internal Audit continue to liaise with management on the application of the principles.

Remobilisation

The draft Remobilisation Plan 4 (RMP4) was considered and approved by the NHS Fife Board in private session on 28 September 2021 prior to submission to the SG, with positive feedback received on 19 November 2021.

An action tracker, outlining key actions and progress on deliverables, has helped support the delivery of the RMP and provided scrutiny of its achievements against target dates. The update to 31 March 2022 was provided to the FPRC on 10 May 2022, with:

- 52 actions completed
- 61 on track
- 20 at risk – require attention
- 12 unlikely to meet target

Actions that are unlikely to be completed are delivery of elective care and diagnostics, and improvements in cancer performance and early diagnosis. Incomplete actions will be carried over into the 2022/23 Annual Delivery Plan.

Risk Management

During 2021/22, the 7 BAFs were reported bi-monthly to standing committees, and

subsequently to the Audit & Risk Committee and the Board. The majority of these BAFs have been updated in year, including updates to reflect Covid19, and have shown positive score changes towards target, albeit Environmental Sustainability and IJB have remained static.

The Risk Management Framework update to the March 2022 NHS Board meeting included the development of the risk profile against the NHS Fife Strategic Priorities/Objectives as follows:

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

Various risks were identified under each priority/objective and following feedback further risks have been identified for Climate Change and Health Inequalities.

A risk management improvement programme was approved by the NHS Fife Board in March 2022. A comprehensive update was provided to the May Audit & Risk Committee including aims and required actions.

A Board-wide review of risk reporting is currently underway and, when concluded, will make recommendations for the reporting of relevant risks to the Standing committees. It is likely that stand-alone Board Assurance Frameworks (BAFs) in use at present will be replaced by a refreshed Corporate Risk Register, with sections pertinent to each standing committee. This will help each Committee define and monitor risks relevant to their remit once the process becomes fully established. This should help improve the consideration of risk within SBARs to the Board and Standing Committees, which still requires considerable development.

Supporting the Board Strategic Risks will be a Corporate Risk Register, featuring risks that have the potential to affect the whole organisation, or escalated operational split into: Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance. In addition, a Risk Dashboard will be developed to enable oversight of the risk level of corporate risks, provide assurance that adequate controls are in place to proactively manage risks, align to improvement actions contained within the Integrated Performance & Quality Report (IPQR) and integrate with Key Performance Indicators (KPIs) and Quality Performance Indicators (QPIs). We also note the intention to refresh the Board Risk Appetite Statement, which should be an important feature of the new system.

Given operational pressures, a Covid19 strategic risk was not included in NHS Fife's extant BAF risk profile. A high level Covid19 risk register is maintained via the Emergency Command structures, which are considered by EDG. At the EDG on 5 May 2022, it was agreed that while some elements of these risks, such as workforce pressures, may remain, they are no longer primarily linked to the pandemic and will now be managed as business as usual, included in the operational risk registers or escalated to the corporate risk register as required.

Performance

NHS Fife has achieved financial breakeven position with non recurring funding of £13.7m received to bridge the financial gap.

The IPQR was presented to each Standing Committee and Board meeting as per each work plan. The IPQR reports on a range of measures covering financial and clinical delivery, with significant challenges highlighted in year.

A review of the IPQR's content and format is currently underway, to address actions from

the Board's Active Governance session and to ensure it remains relevant and clear to Board members.

The IPQR to the May 2022 FPRC provided the latest reported performance for 2021/2022, with data provided to end of March 2022 for Remobilisation Activity and all other targets to February 2022.

Cancer 31-Day Diagnostic Decision to first Treatment (DTT), Inpatient Falls, SABs - HAI and Antenatal are meeting target, with six indicators not achieving target but performing well above the Scotland average: C-Diff Community; 4- Hour Emergency Access; Cancer 62 Day RTT; Patient TTG; New Outpatients; Delayed discharge – Standard Delays.

A further eight areas are neither meeting the target nor the Scotland average: Diagnostics; 18 week RTT; Detect Cancer early; Cancer 62 Day RTT; Delayed Discharge (% bed days lost); Smoking Cessation; CAHMS Waiting Times; Psychological Therapies. Improvement actions to address these areas are included in the IPQR and will take time to embed, and we note that many of these areas are still performing well against the Scottish average.

Integration

The final version of self-evaluation response to the Ministerial Strategic Group (MSG) Integration of Health & Social Care report was submitted by Fife IJB to Scottish Government in May 2019, and detailed areas for further work locally. An update on progress was provided to the Fife IJB Audit & Risk Committee in April 2022, which showed some progress but a number of actions still outstanding. There would be benefit in the NHS Fife Board or a Standing Committee also receiving this report, as the responsibility for implementing actions also lies with the partner bodies, who are reliant on the success of the IJB in a number of key areas.

The NHS Fife Director of Health and Social Care advised the 29 March 2022 Board Meeting that the Integration Scheme (IS) had been formally signed off by Scottish Ministers on 8 March 2022.

Internal Audit has continued to provide advice and highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk. Internal Audit F05-22 - Strategic Plan is reviewing the process for developing the Fife IJB Strategic Plan. The Fife IJB Strategic Risks were reviewed, updated and presented to the January 2022 meeting of the Fife IJB.

We previously noted that the Integration BAF was significantly out of date and needed to be reviewed. This will be considered as part of the updating of the NHS Fife Risk Management Framework; with the Director of HSCP recommending that the current risk is closed as the Integration Scheme is complete.

Other Governance Areas

General Policies

As reported to the May 2022 FPRC, as at April 2022, 29 (51%) of the 57 General Policies are up to date. 10 (17%) remain beyond their due date and are presently being followed up. Work is underway for 18 (32%) of General Policies, which are either being reviewed or are out for consultation to the General Policies Group. Completion has improved since the last report in November 2021.

Corporate Objectives

During April/May 2022 the Standing Committees endorsed and the Board approved the NHS Fife Corporate Objectives which will inform the development of the Annual Delivery Plan for

2022/23.

Annual Review Letter

The outcome letter from the Scottish Government Annual Review for NHS Fife was received in February 2022 and presented to the March 2022 NHS Fife Board meeting. Overall the feedback received was positive, in particular the organisational actions to the impact of Covid19 and associated activity.

Board and Standing Committee Development Sessions

We commend the timetabling of development sessions for 2022-23 which will provide an understanding in advance of business proposals to Board members and help members to scrutinise papers and understand the topics as they arise at meetings.

Board and Standing Committee Work Plans and Annual Reports

The Audit & Risk Committee will present its annual work plan to each meeting in 2022/23 which will enable the Committee to monitor items that have been completed, carried forward to a future meeting or removed. We recommend that this good practice is extended to all Standing Committees and the Board.

All standing committees' draft annual reports are broadly in line with the FTF Committee Assurance Principles and will be presented to the 16 June 2022 Audit & Risk Committee.

Blueprint for Good Governance and Active Governance

An update was presented to the NHS Fife Board in January 2022 reporting all actions from the initial assessment against the Blueprint for Good Governance as complete.

A Board Development session was held on 2 November 2021 on Active Governance, with a focus on improving how data is presented to the Board and Standing Committees, and how insights from intelligence can be used to assure quality and performance. A plan including a number of actions to improve reporting was agreed. The action plan is due to be completed during the summer of 2022 and then reported to the Board, and will include the recently updated Blue Print for Good Governance.

Code of Corporate Governance

An update to the NHS Fife Code of Corporate Governance was due to be presented to the Audit & Risk Committee in May 2022, but has been delayed to allow the recently issued Model Code of Conduct to be included in the next iteration.

Action Point Reference 1 – MSG Report	
Finding:	
Over the last few years a number of the MSG indicators have progressed but due to Covid there are a number outstanding. An update was provided to the Fife IJB Audit and Risk Committee in April 2022 but no update has been provided to the NHS Fife Board.	
Audit Recommendation:	
NHS Fife should be provided with an update/precis on work being undertaken to foster closer working relationships with colleagues in local authorities and IJBs.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
A report on the MSG indicators will be presented to the Finance and Performance Committee as a standing committee of NHS Fife Board.	
Action by:	**Date of expected completion:**
Director of HSCP	**September 2022**

Clinical Governance

BAF Risk:

Risk 1674 – Quality & Safety – High Risk (15)

- There is a risk that due to failure of clinical governance, performance, and management systems (including information and information systems), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID – 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery

Risk 1677 – Digital & Information – High Risk (15)

- There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Annual Report

The Clinical Governance Committee (CGC) annual report provided a reflective and nuanced conclusion that the Committee had fulfilled its remit and that adequate and effective clinical governance arrangements were in place throughout NHS Fife during the year. The narrative in the report includes detailed commentary on key areas including pandemic related activity, the risk based approach taken to service pause during the pandemic and mitigating action taken to minimise the impact of this on patient treatment and diagnosis. The report also highlighted business considered during the year including the establishment of the Public Health and Wellbeing Committee, Remobilisation Planning, Population Health and Wellbeing Strategy development, Primary Care Improvement Plan, Complaints Backlog and how this is being addressed, New legislative requirements, New Participation and Engagement Advisory Group, Urgent Care Redesign, East Region Formulary development, Independent review of Paediatric Audiology Services, Revised Integration Scheme, Annual Reports from supporting groups and relevant internal audit and external regulatory body reports.

Pandemic & Immunisation

The CGC received updates on different aspects of work related to the pandemic including the Covid19 vaccination programme and the governance around it and the wider vaccination programme, testing and tracing, communication, infection rates, pressures on services and pausing of elective services and outpatient activity.

An external review of all immunisation programmes in NHS Fife subsequently made recommendations to allow NHS Fife to meet the increasing demands and expectations for childhood and adult immunisation programmes. Recommendations were approved by the EDG at their 6 May 2021 meeting and the Fife Immunisation Strategic Framework 2021-24 was considered and supported by the CGC in September 2021 along with the flu and Covid19 booster immunisation programmes.

Clinical and Care Governance Strategy and Framework

Engagement with staff throughout NHS Fife and the Health and Social Care Partnership has

taken place regarding the draft NHS Fife Clinical and Care Governance Strategic Framework which is to be finalised and presented to the Clinical Governance Committee for endorsement at their meeting on 1 July 2022, later than expected due to service pressures associated with the pandemic. Internal Audit have been consulted on the strategy and have provided comment on governance, integration and assurance aspects as well as on the extent to which the strategy meets the requirements of previous internal audit recommendations.

CGC Governance and Assurance

A Public Health and Wellbeing standing committee has been established with responsibilities related to public health and wellbeing strategy development and assurances regarding this and public health initiatives that were previously within the remit of the CGC. Although terms of reference and workplans have been reviewed, the CGC annual assurance report acknowledges the need for further work to avoid unnecessary duplication and ensure clarity over the different roles and responsibilities of standing committees.

The Clinical Governance Oversight Group has merged with the Duty of Candour and Adverse Events Group and has a revised Terms of Reference which include responsibility for provision of an annual assurance report to the CGC. A newly formed Organisational Learning Group reports to the Clinical Governance Oversight Group, with one of its duties being to review the consistency of external and internal reports.

Risk Management

In response to our finding and recommendation in our 2020/21 Internal Audit Annual Report (B06/22 - pt 1) the Quality and Safety BAF risk was updated by the CGC to reflect the increased risk of morbidity/mortality as a result of necessary reprioritisation of service provision associated with the response to the pandemic as follows: '*There is a risk that due to failure of clinical governance, performance and management systems (including information and information systems), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the Covid 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery*'. The Quality and Safety BAF is linked to relevant operational risks including risks 2214 (staffing levels), 1904 (pandemic associated increased morbidity, mortality and reduced capacity), 1907 (Pandemic associated oversight of Care Homes).

External Review

The NHS Fife CGC Annual Assurance Report referred to the reviews undertaken by regulatory bodies which were reported to CGC during the year along with assurance regarding action being taken to address recommendations made in the reports. The following reports were considered by CGC in 2021/22:

- Healthcare Improvement Scotland (HIS) Healthcare Associated Infection (HAI) inspection - Glenrothes Hospital (7-8 July 2020)
- HIS HAI inspection - Adamson Hospital (28 October 2020)
- HIS Covid focused inspection – Victoria Hospital (May 2021)

In addition the Clinical Governance Oversight Group considered the following additional reports as well as routinely considering the activity tracker including inspection reports. Consultations, reports and publications for awareness and published standards:

- Multi-agency Adult Support and Protection inspection was carried out in Fife between May and August 2021 to provide assurance to the Scottish Government about local partnership areas effective operation of adult support and protection processes and leadership for adult support and protection services

The following reports were referred to in Executive Director Letters but were not reported to the CGC or CGOG:

- Mental Welfare Commission Inspection of Ravenscraig Ward, Whytemans Brae, on 30 September 2021 (update provided to Clinical & Care Governance Committee on 20 April 2022)
- Mental Welfare Commission Inspection of Dunino Ward, Stratheden on 2 November 2021.

Significant Adverse Events

A new post of Lead for Adverse Events has been recruited to and the Lead is co-ordinating the implementation of the Adverse Events improvement plan which includes the review and revision of the Adverse Events Policy. We have been advised that the revised policy will address relevant recommendations in internal audit reports (B08/22, B20/21 & B14/21).

Organisational Duty of Candour

The Annual Duty of Candour (DoC) report covering the 2020/21 financial year was presented to Fife NHS Board at their 29 March 2022 meeting. Neither CGC nor Fife NHS Board have received any information on the application of DoC during 2021/22. The Medical Director has informed us that delays to the adverse event process in its entirety are a known consequence of the impact of the Covid-19 pandemic on service pressures. Recovery to a state where more timely reporting is heavily dependent on the recovery of the backlog of closure of adverse event reviews. .

Clinical Policies and Procedures

The latest report to the Clinical Governance Oversight Group in April 2022 indicated that 97% of Clinical Policies and Procedures had been reviewed by their scheduled review date.

Health and Safety

The 2021/22 Health & Safety Sub-Committee Annual Report confirmed that there were no significant control weaknesses or issues at the year-end which it considered should be escalated to the Clinical Governance Committee or disclosed in the Board's Governance Statement.

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.**

Workforce Planning and Risk Assurance

The Staff Governance Committee (SGC) considered the draft Interim Workforce Plan on 20 April 2021 prior to submission to SG by the deadline; with final endorsement by the Committee on 15 June 2021. The Interim Workforce Plan complied with the Scottish Governance guidance and template, and reflected workforce elements of the RMP4. No specific update on delivery of the Workforce Plan for 2021/22 has been provided to the SGC; instead the SGC has been advised of its implementation via updates on the RMP4. Whilst this enables the SGC to be kept informed of the workforce actions taken, it does not provide a conclusion on the success in implementing the Workforce Plan for 2021/22 or of its impact on the key workforce risks facing the Board. Whilst compliant with SG direction and timetables, workforce planning remains an area of high risk which is fundamental to the achievement of NHS Fife's strategic objectives and will be integral to the design and delivery of a sustainable Population Health and Wellbeing Strategy.

The National Workforce Strategy for Health and Social Care in Scotland was published in March 2022, and on 1 April 2022, the SG issued associated guidance which required Boards to submit three year integrated health and social care Workforce Plans by 31 July 2022. The risk profile of the national strategy is not available, but our assessment would be that a number of assumptions within the document are very high risk.

The NHS Fife Workforce Strategy will need to inform and be informed by the overall strategy of the Board. When the new Workforce Strategy is presented to the SGC, there would therefore be considerable benefit in a companion paper which describes how it will be monitored by the SGC, how it fits in with Population Health and Wellbeing Strategy and is connected to the developing IJB Strategic Plan e.g. delegated health services, how the associated risks will be identified and consolidated within the new risk register and how assurance will be provided on progress.

The SGC continued to receive regular assurance reports on the strategic workforce risks and received a detailed review of the Workforce Sustainability BAF in October 2021. The workforce risks remained at high; but with greater consideration to workforce sustainability risks relating to service delivery as set out in the Clinical Strategy and the future Health and Wellbeing Strategy, plus the impact of the Covid19 pandemic.

Internal Audit is completing a review of the processes relating to the development of the 2022-25 Workforce Strategy and Workforce plan, using the Workforce Sustainability BAF as the basis to evaluate the design and operation of the controls to inform the Workforce Plan.

Staff Governance Assurances

Reports, such as the Health and Wellbeing Update, indicate that a lot of work is ongoing to meet the Staff Governance Standards (SGS), but there is no reference within such reports as to the specific strands of the SGS that they are addressing or to the resulting outcomes. The SGC also did not receive comprehensive assurance on compliance with the SGS throughout

the year, with only verbal updates on the action taken to meet the SGS being provided at the September 2021 and March 2022 SGC meetings.

The SGC annual report 2021/22 reported that the committee received individual papers to demonstrate that the five strands of the SGS are being met. More detailed, written assurances are required in future to evidence such a conclusion.

Remuneration Committee (RC)

The RC completed an annual assessment of its performance for 2021/22 at its April 2022 meeting. No issues were identified for improvement, with a training session being arranged to further enhance members understanding of their responsibilities. The RC now keeps an Action List to ensure matters carried forward from each meeting are actioned.

Promoting Health and Wellbeing, Appropriately Trained & Developed, and COVID-19 Response

Regular reports have been made to SGC meetings on the impact of the Covid19 pandemic and provision of assurance on the evolving measures being taken to ensure NHS Fife's workforce is being supported during the pandemic. Our review of the Staff Health and Wellbeing update reports presented to the SGC evidenced a good level of detail and showed that NHS Fife continues to respond to the workforce issues presented by the Covid19 pandemic.

The draft Workforce Plan 2022-25 includes an action to consider succession planning implications for critical roles, including advanced practitioners grades and above. It also includes a workforce profile overview for the different medical specialities and each includes a number of actions to sustain each speciality or professional group e.g. Pharmacy Workforce, including training and development.

The sickness absence statistic for March 2022 was 5.59%, which although still high is showing a downward trend since December 2021, when it was 6.98%. For 2021/22, it is reported that there was a staffing reduction of 1.87% due to Covid19.

Appraisal

TURAS appraisal completion continues to be impacted by the Covid19 pandemic, with a 31% completion rate at the end of March 2022. The Area Partnership Forum, which supports partnership working to improve performance, receives updates on both TURAS appraisal and training arrangements, with the SGC receiving copies of its minutes. Arrangements are proposed to include TURAS appraisal performance reporting as part of the IPQR reporting cycle for 2022/23, with reporting to each SGC meeting.

As at 31 March 2022, Medical Appraisal and Revalidation data shows that of 302 Primary Care doctors, 96.7% were appraised and out of 330 Secondary Care doctors 88.8% were appraised. Internal Audit was informed that although appraisals are slowly getting back to normal, there is still a shortage of appraisers in Secondary Care, which has resulted in some being delayed in addition to the existing pressures resulting from Covid19. An update on the appraisal process has recently been issued by the Scottish Government, confirming that the more flexible approach to appraisal recommended over the previous two years should be continued at present. This includes flexibility regarding the amount of supporting information required.

Staff Governance Annual Monitoring Return

The SG advised all health boards in April 2022 that a different approach was being taken to the review of the monitoring return for 2020/21 in recognition of the continuing pressures faced by Boards. As a consequence no further actions/recommendations are being made by

the SG, based on the 2020/21 monitoring return. Although a more streamlined exercise was completed, NHS Fife was advised that the exercise will still allow the SG to measure the application of the SGS and to identify areas of good practice that will be shared to help drive continuous improvement across all NHSScotland Health Boards. The SGC will be advised of the outcome of this exercise once confirmation of the 2021/22 monitoring return format is received from the SG.

Whistleblowing

The SGC and NHS Fife Board were previously advised of the launch of the National Whistleblowing Standards from 1 April 2021 and during 2021/22 it has received updates on how the new standards were being rolled out, including Quarterly Reports detailing the number of concerns raised. Consideration is still being given to the level of detail provided to the SGC to keep it informed on the action taken to address concerns raised. A Whistleblowing Annual Report for 2021/22 will be presented to the September 2022 SGC meeting and thereafter to NHS Fife Board.

Action Point Reference 2: Staff Governance Assurances	
Finding:	
Reports provided to the SGC detailing the actions taken to meet the SGS do not specify which strand they are addressing. In addition, the SGC also did not receive comprehensive assurance on compliance with the SGSs throughout the year, with only verbal updates on the action taken to meet the SGSs being provided at the September 2021 and March 2022 SGC meetings. The SGC annual report 2021/22 reported that the committee received individual papers to demonstrate that the five strands of the SGSs are being met. More detailed, written assurances are required in future to evidence such a conclusion.	
Audit Recommendation:	
To enable the SGC to fully conclude that the SGSs are being met, written reports indicating how ongoing workstream and other activity meets the appropriate SGS(s) should be presented to it in accordance with its Workplan. Any related reports, such as the Health and Wellbeing Update, should also state which strands they provide assurance on and where possible report on the impact as well as the implementation of any actions taken.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
Work is already underway to respond to this assessment and recommendations **In future all reports to Staff Governance Committee will, where appropriate, include an explicit reference to the SGS(s) the paper meets.**	
Action by:	**Date of expected completion:**
Director of Workforce, with specific action taken by the authors of papers to SGC	**November 2022**

Financial Governance

BAF Risk:

Risk 1671 – Financial Sustainability – Moderate Risk (9)

- There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred.
- There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.
- Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.

Risk 1672 – Environmental sustainability – High Risk (20)

- There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation

Financial Performance

The draft financial outturn position to 31 March 2022, subject to external audit review, was:

- A £0.380 million under spend on the core Revenue Resource Limit (RRL) of £920.02 million
- A break-even position against the core Capital Resources Limit (CRL) of £32.389 million
- 2021/22 savings delivered of £9.618 million, of which £5.779 million (60%) was recurring,

Total additional Covid19 funding of £95.189m was received from SG in 2021/22. Board Directed Services accounted for £36.464m of the Covid19 costs, and the balance of £58.725m was allocated to the HSCP.

The draft year-end figures for the Health and Social Care Partnership were breakeven for Health delegated, a £1.690m under spend for Social Care with the Fife IJB having a reserve balance of £78.843m.

Financial reporting throughout the year to the FPRC and Board remained consistent and the position was clearly presented, along with the impact of Covid19. Financial forecasts during the year provided an accurate outcome of the year-end position.

Efficiency Savings

The 2021/22 financial plan reflected an overall savings target of £21.7m and assumed £8m was achievable in-year with £4m on a recurring basis and £4m on a nonrecurring basis. Throughout 2021-22 the savings shortfall of £13.7m, as identified in the financial plan, remained a risk to financial balance and Scottish Government (SG) assistance was required. The SG required NHS Fife to deliver a series of actions prior to providing £13.7m to enable NHS Fife to break even for 2021-22.

Significant financial challenges remain as NHS Fife emerges from emergency footing and the Financial Improvement and Sustainability Programme (FISP) will require to ensure there is the required capacity to deliver substantial cost reduction to achieve financial balance in 2022-23 and beyond. The FISP has now been established and its remit endorsed at the January 2022 FPRC. The programme aims to develop and agree productive opportunities and savings targets for 2022/23 and plans for the more medium-term. The Programme will

report directly into the Portfolio Board with governance reporting in place to other Standing Committees and the Board.

Financial Planning 2022/23 and Covid Funding

The Strategic financial plan 2022/23 was approved by the Board on 28 March 2022. This identified a projected budget gap for 2022/23 of £24.1m with plans for this to be mitigated in part through a range of cost improvement plans and a significant capital to revenue transfer. The forecast financial position after the application of these proposed actions is a deficit of £10.4m. A 3-year medium-term plan is being developed to identify a range of cost improvement activity to ensure recurring financial balance at the end of that 3 year period. NHS Fife remain within 0.8% from the full NRAC share.

The Strategic Financial Plan highlighted the risk that Covid19 funding would not match additional costs, but did include provision for Covid consequentials. Subsequently, the SG have advised that "*the UK Government has indicated that in 2022-23 there will be no further specific consequentials to meet the ongoing cost pressures with managing Covid19*."

This guidance was highlighted in a paper to the May FP&R on the budgetary process. However, the paper also stated that '*The financial plan does not assume the continuation of SG funding for Covid19 costs*', which is not necessarily consistent with the information presented in the March budget. The Director of Finance & Strategy has advised Internal Audit that *"the inconsistency arose due to the timing of the recent notification from Scottish Government that there would be no further Covid consequentials, prior to that i.e., in March 2022 the assumption all Boards had made was that Covid consequentials would continue into 2022/23, albeit at a reduced rate. The IJB Covid reserve is earmarked to cover health delegated budget costs which include acute set aside and therefore that aspect of Covid cost will be funded from that source. The Scottish Government also advised on 1 June 2022 that an additional £7.5m for health board retained acute Covid costs will be allocated*."

Now that this risk has crystallised, the financial impact on NHS Fife budgets for 2022/23 is being fully quantified, as it may lead to an increase in the year-end deficit which will generate the need for even more savings in future years. This aspect of financial planning is currently being reviewed and will be reported to the FPRC and the Board by the end of Quarter 1.

We have been informed that the current Financial Sustainability BAF will be split into two new corporate risks. One will focus on in year delivery of the current financial plan and the second will consider the wider delivery of the 3 year financial plan. This approach should provide a more detailed and focussed management of financial risks as part of the updating of the NHS Fife Risk Framework. The Financial Plan did list a number of constituent risks to financial balance, not all of which were reflected in the BAF; these should be assigned to the relevant strategic financial risk in future where that is deemed appropriate.

Capital Planning and Asset Management

The Five Year Capital Plan 2022/23 was endorsed at the March 2022 FPRC and approved at the NHS Fife Board meeting.

The November 2021 FPRC received the Property and Asset Management Strategy (PAMS) report for the year to 31 March 2021, which is not mandatory but good practice. The PAMS itself was largely retrospective but emphasised the need for a revised NHS Fife Property & Asset Management Strategy to support the development and deliver the objectives of the future Health & Wellbeing Strategy.

Within the 2021/22 ICE report we highlighted the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 and onwards, which will include

actions and outcomes. The development of this plan will be included as part of the process to develop the 2022 PAMS.

The PAMS and Capital Programme will be a vital enabler of the Health and Wellbeing Strategy. Internal Audit previously highlighted the absence of a BAF or operational risk for the Capital Programme and Property Strategy and is pleased to note that the intention is to develop a Property Corporate Risk.

The FPRC receive regular updates on current major capital projects. The Fife Elective Orthopaedic Centre (FEOC) Project is on track and due for completion in October 2022 and plans to be operational in January 2023, with progress regularly reported to the FPRC. Updates to the FPRC highlight the need for an additional 38.5WTE staff above the numbers originally envisaged to allow the FEOC to be fully operational by end of 2022. The reason for this increase was fully reviewed with the Scottish Government who approved additional Scottish Government funding to cover it.

BAF – Financial Sustainability – Moderate Risk

The Financial Sustainability BAF, as reported to the FPRC during 2021/22, recognises the ongoing financial challenges facing the Board, in particular Covid19 funding and savings gaps. The risk score has reduced in year with the confirmation of non repayable funding support from the SG. The BAF risk remains as Moderate, reflecting the underlying financial gap going into 2022/23. We would expect the absence of funding for net additional costs for Covid 19 to be reflected in the risk score.

We note the future ambition that the Financial Sustainability BAF would be split with one part focusing on financial performance and the other would be a risk on financial improvement and sustainability for the medium-term. This approach will allow for clearer linkages to strategy and savings programme.

BAF – Environmental Sustainability – High Risk and Environmental Reporting

A paper was presented to the September 2021 FPRC detailing NHS Fife's ambition to improve the energy efficiency of its buildings, as part of the health sector's drive towards 'net zero carbon' and with funding available from the SG as part of the Low Carbon Infrastructure Programme.

A Policy For NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, setting out mandatory requirements with immediate effect. A briefing paper for the DL was taken to the Board and Public Health and Wellbeing Committee in May 2022. The DL requirements will almost certainly impact on all NHS Fife Board decision making.

The extant BAF has not materially changed during 2021/22 as the major risk is contingent on the delivery of the Fife Elective Orthopaedic Centre (FEOC) to remove inpatients from the tower block at the Victoria Hospital. As noted above, the Director of Property & Asset Management will develop an appropriate corporate risk including the impact of the net-zero requirement.

Best Value

The draft FPRC Annual Report was presented to the FPRC in May 2022. The report concludes on the NHS Fife Best Value arrangements and reflects on the introduction of both the SPRA and FISP which overall "*facilitates a more effective triangulation of workforce, operational and financial planning*" to supporting the delivery of best value across its resource allocations. The FPRC Annual Report also considered the achievement of Best Value characteristic.

Action Point Reference 3: NHS Fife PAMS Implementation Action Plan	
Finding:	
The ICE highlighted the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 and onwards, to include actions and outcomes and be used by the Capital Groups to assess progress in achieving PAMS outcomes and objectives. We have been informed by management this is not an actual document, but is a 'living plan' that is evidenced by discussions at various Capital Groups.	
Audit Recommendation:	
The Implementation Plan for delivering the PAMS should be properly documented, approved and monitored to ensure the delivery of actions and outcomes and provide assurance to the Board that the PAMS is being delivered.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
An Implementation Action Plan will be developed as part of the 2022 PAMS.	
Action by:	**Date of expected completion:**
Director of Property & Asset Management	**30 November 2022**

Information Governance

BAF Risk:

Risk 1677 – Digital & Information – High Risk (15)

- There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Governance Arrangements and Assurance Reporting

Reporting to the Digital and Information Group has been consistent throughout the year; both groups provided update reports to the Clinical Governance Committee during the year and Annual Assurance Reports/Statements at year-end.

In 2021/22 the format of reporting to the Information Governance and Security Steering Group improved and is now standardised with an Activity Tracker and Assessment against key measures now being provided to each meeting. Improvements have also been made to the quality and availability of data for the key measures report, albeit data is not yet available for some measures such as training/education and records management.

We commend the work of the Director of Finance and Strategy, Medical Director and Associate Director of Digital and Information in driving and supporting the considerable improvements made to assurance reporting, particularly to IG&SSG.

The IG&S Operational Group has not met as often as intended in 2021/22 due to service pressures and staffing resource issues in the IG&S Team and as a result the relationship between the Operational Group and the Steering Group is not yet fully resolved.

The improvements in the assurance reporting and governance arrangements, and scheduling of reporting throughout 2022/23 to the CGC in its annual workplan, have completed recommendations made in previous internal audit reports (B08/21, B28/21 & B08/22).

Digital and Information Strategy

Updates on the NHS Fife Digital and Information Strategy 2019-2024 were provided to the September 2021 and March 2022 Clinical Governance Committee meetings. The latest update recognised that '*the Digital strategy would have benefited from a resourcing and financial assessment to achieve the stated ambitions*' and '*noted the impact of the COVID-19 pandemic response and the requirement to align activities to the evolving risk profile within the Digital and Information domains*'. The CGC have been informed of a new prioritisation process launched in February 2022 in order to align the digital deliverables to their operational and strategic requirements and agree a prioritised workplan consistent with available resources, including the use of a revised prioritisation matrix to balance the adoption of existing digital capabilities with the implementation of new ones.

Whilst resources have increased, and there is now a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered, it is clear that elements of the strategy will not be delivered by the end date of 31 March 2024. The CGC should therefore be notified of these changes, and informed of the impact that this will have on the strategic objectives of the Board.

Risk Management

The format of risk reports presented to IG&SSG and D&I Board have improved throughout 2021/22 and all risks were reviewed to ensure the scores reflected the impact of the pandemic. The new format includes graphical representation to highlight risks with improved or deteriorating ratings and provides detailed analysis on the highest ranked risks which provided the Group with additional understanding of the risk and allowed them to provide assurance on whether management actions would mitigate the risk within a suitable timescale.

The latest Digital and Information BAF presented to CGC on 29 April 2022 highlighted the increased threat of cyber attack due to the war in Ukraine.

External Review

The IG&SSG received detailed update on the NIS Audit throughout the year, with the in March 2022 estimating current compliance of 73% with additional assurance that evidence to demonstrate implementation of previous recommendations was underway, ahead of the review audit to be undertaken by the Competent Authority in April 2022. The review audit was completed for 2022 and the report received detailing an overall compliance status of 76%, an increase from 69% achieved in 2021.

IG&SSG await final feedback from the Keeper of the National Records of Scotland on NHS Fife's draft Records Management Plan submitted in February 2021.

The Information Commissioners Office (ICO) will be auditing Boards in NHS Scotland against its accountability framework; NHS Fife is due late summer 2022. In preparation, a self assessment was presented to CGC on 10 March 2022 which considered the 343 activities associated with the 10 categories and 77 expectations in the framework and concluded that:

- 84 activities had yet to start
- 146 activities had been started but were not complete
- 113 activities had been completed and can be evidenced as such.

Information Governance Incidents

Through the year, 14 incidents were reported to the ICO, an increase of 3 on the previous year. Of the 14, 9 (64%) were reported within the 72-hour requirement. Of the 14 incidents, 13 have been confirmed not to require any further follow up and 1 item rejected as it was deemed to not meet the criteria. At present there is no requirement for these to be disclosed in the Board's annual Governance Statement.

ITIL Processes

In response to internal audit B23-21 – ITIL Processes, the D&I Board supported the introduction of Information Technology Infrastructure Library (ITIL) Version 4 to support strategic planning, design, build activities and the efficient running of operations and service management to further enhance the availability of systems and digital capability.

Action Point Reference 4: Delivery of D&I Strategy 2019/24	
Finding:	
Whilst resources have increased, and there is now a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered, it is clear that elements of the strategy will not be delivered by the end date of 31 March 2024.	
Audit Recommendation:	
The CGC should be notified in 2022/23 of any elements of the D&I Strategy that will not be delivered by 31 March 2024 and the impact that this will have on the strategic objectives of the Board.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The element of digital strategy that will not be delivered in full or in part will be identified to the CGC. The initial identification will take place for the 1 July meeting; with the fuller impact assessment being presented as part of the strategy update report on 13 January 2023, as per the Committee's work plan. **This will be evidenced through the committee's minutes.**	
Action by:	**Date of expected completion:**
Associate Director of Digital & Information	**March 2023**

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2021/22	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by 30 June.	Yes	Draft presented May 2022	No (July 21)
2	Annual Internal Audit Report presented to Audit & Risk Committee by June	Yes	Presented Audit & Risk Committee – June 2022	No
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	79%
4	Draft reports issued by target date	75%	67%	59%
5	Responses received from client within timescale defined in reporting protocol	75%	100%	68%
6	Final reports presented to target Audit & Risk Committee	75%	67%	47%
7	Number of days delivered against plan	100% at year-end	67%	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	91%	77%
9	Skill mix	50%	80%	77%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3.5	Bar chart	

Assessment of Risk

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

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	None
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	Four (Ref 1,2,3,4)
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	None

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 July 2022**
Title:	**BAF – Financial Sustainability**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Consideration
- Approval

This report relates to a:

- Annual Operational Plan
- Emerging Issue
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to update the Committee on the BAF for Financial Sustainability and the associated risks.

The Committee has a vital role in scrutinising the risk and where indicated, Committee chairs will seek further information from risk owners. This report provides the Committee with an update on NHS Fife BAF specifically in relation to Financial Sustainability as at 30 June 2022.

2.2 Background

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

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

The Committee is invited to consider the following:

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

2.3 Assessment

The Committee can be assured that systems and processes are in place to monitor the financial performance and sustainability of NHS Fife, including the potential impact of the financial position of the Integration Joint Board.

The high-level risks are set out in the BAF, together with the current risk assessment given the mitigating actions already taken. These are detailed in the attached papers. In addition, further detail is provided on the linked operational risks on the corporate risk register. Each risk has an owner who is responsible for the regular review and update of the mitigations in place to manage the risk to financial sustainability and strategic planning.

Through the Code of Corporate Governance, the Board has delegated executive responsibility to the Chief Executive and Director of Finance to ensure the appropriate systems and processes operate effectively to manage and mitigate financial risk on behalf of NHS Fife. The Finance, Performance & Resources Committee is tasked on behalf of the Board to provide appropriate oversight and scrutiny of the associated financial performance. The accountability and governance framework associated with the financial performance of the organisation are key aspects of both internal and external audit review. Individual Directors and managers, through the formal delegation of budgets, are accountable for financial management in their respective areas of responsibility, including the management of financial risks.

The attached schedule reflects the position at 30 June 2022. Since the last update (31 March 2022) the BAF current score has been reviewed and updated to High for 2022/23.

Despite the mitigating factors detailed below

- The IJB Chief Officer and the Board's Director of Finance have agreed an approach to deploy the earmarked COVID reserve carried forward from 2021/22 by the IJB to support ongoing additional COVID expenditure across the H&SCP and health delegate services.

- Confirmation from Scottish Government of a COVID funding envelope to support ongoing COVID expenditure within non delegated health services during 2022/23 with a significant emphasis on cost mitigation.

- Significant work on both a national and local scale has commenced to mitigate the costs of managing COVID to be affordable within existing resources.

the risk to the board of not achieving delivery of its financial targets in 2022/23 is high. The current challenges to the financial position include the following:

- Scottish Government have indicated to all boards a significant financial challenge for 2022/23 and beyond and whilst our financial plan for 2022/23 signals to Scottish Government a funding gap in year of £10.4m, SG have requested to improve this position we consider how best to utilise all core and earmarked funding.

- Although access to Covid funding support is available, due to high inflation levels and service pressures the available funding may not be sufficient to over the costs of manging the pandemic.

- Ongoing high levels of activity across unscheduled care continues to create financial pressure.

- Challenging service pressures along with workforce fatigue may impact on the ability to deliver on cost improvement plans

- Uncertainty remains in relation to funding allocations from Scottish Government.

However, In order to drive financial sustainability across the organisation, the Financial Improvement/Sustainability (FIS) Programme is underway and is supported by increased capacity within the Corporate Programme Management Office. This programme will report through the Portfolio Board and aligns firmly with one the strategic priorities to "Drive Value and Sustainability". This is a key enabling programme to support the delivery of our 2022/23 corporate objectives and longer-term strategy development.

2.3.1 Quality/ Patient Care

Effective financial planning, allocation of resources and in-year management of costs supports the delivery of high-quality care to patients.

2.3.2 Workforce

Effective financial planning, allocation of resources and in-year management of costs supports staff health and wellbeing and is integral to delivering against the aims of the workforce plan.

2.3.3 Financial

Please refer to the full report at Annex 1.

2.3.4 Risk Assessment/Management

Please refer to the full report at Annex 1.

2.3.5 Equality and Diversity, including health inequalities

Effective financial planning, allocation of resources and in-year management of costs includes the appropriate equality and diversity impact assessment process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the NHS Fife financial planning, allocation of resources and in-year management of costs processes.

2.3.8 Route to the Meeting

Executive Directors' Group on 7 July 2022.

2.4 Recommendation

The Committee is invited to:

- **Consider** the questions set out above; and
- **Approve** the updated financial sustainability element of the Board Assurance Framework

3 List of appendices

The following appendices are included with this report:

- BAF – Financial Sustainability
- BAF Risks – Financial Sustainability Linked Operational Risks

Report Contact

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	31/05/2022	31 July 2022	There is a risk that the board will not achieve its financial targets in 2022/23 due to the inability to deliver the level of cost improvement plans required, the costs of managing the ongoing global Covid 19 pandemic exceed available funding, the increasing cost of very challenging unscheduled care service pressures and insufficient available resource to support the recovery of elective care services.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Although agreement has been reached with IJB CFO in relation to partnership approach to funding support from Covid reserve carried forward by the IJB for both partnership and health delegated services and a further COVID financial envelope made available by SG to support health non delegated services, there remains the risk that the cost of manging the pandemic will exceed the available funding. The challenges involved with managing increasing services pressures could impede the achievement of cost improvement plans.	Margo McGurk Director of Finance and Strategy	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* 2022/23 Financial Plan approved by NHS Board in March 2022. Cost improvement plans of £11.7m and capital to revenue transfer of £2m approved to mitigate the initial funding gap of £24m. Remaining Funding gap of £10.4m with plans to mitigate over the medium term. Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation. Capacity within the Corporate Programme Management office has been increased to provide support to deliver on the FIS programme. Agreement has been reached with IJB CFO on partnership approach to the use of the Covid reserve carried forward by the IJB to support Covid expenditure across the partnership and Health delegated Services. Covid financial envelope to support non delegated Health services has been provided by Scottish Government Covid expenditure to be mitigated wherever possible either by stopping spend or absorbing into business as usual resources. All cost improvement opportunities to be shared by and with all NHS boards across Scotland through the establishment of national cost improvement workstreams	Nil	1. Continue to develop all opportunities identified through the FIS programme cost improvement pipeline tracker in the context of sustainability & value. 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the social care forecasts and the likely outturn at year end.	Current performance very challenging with ongoing financial consequences of Covid 19, significant cost pressures associated with workforce and medicines due to high levels of unscheduled care activity, enhanced costs of recruitment and retention issues and rising inflationary costs. Cost improvement plans continue to be developed with 6.4% of approved CIP target delivered to end of May 2022.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Financial risks will always be prevalent within the NHS / public sector and it would be reasonable to aim for a position where these risks can be mitigated to an extent. However, SG have indicated significant financial challenge in year which requires robust mitigation and may impact availability of SG funding allocations.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1363	Health and Social Care Integration	Active Risk	Moderate	9	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active Risk	Low Risk	6	McCormick, Neil
1364	Efficiency Savings	Closed Risk	High Risk	16	McGurk, Margo
1784	Finance (Short Term/Immediate)	Closed Risk	Moderate	8	Connor, Nicky
1846	Test and Protect/Covid Vaccination	Closed Risk	Low Risk	6	Connor, Nicky

ID	
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, NHSFBD - Finance Directorate Risk Register, NHSFBD - Prescribing & Medicines Management Risk Register
Opened	30/03/2006
Title	Prescribing and Medicines Management - Prescribing Budget
Description	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	9
Current Management Actions	05/05/22 - Finance advised that Final year position was a slight underspend not break even and that the uplift to the H & SCP budget had been allocated in line with SG guidance. 27/4/22 - GP Prescribing is £68k underspent at February, on an annual budget of £74.7m; forecast year-end position is breakeven. £400k to the end of Q2 has been recharged to COVID funding in line with national guidance. Hospital prescribing is £1.7m overspent at February, on an annual budget of £38.27m. Current year efficiency savings in Acute is £136k with a recurring benefit of £77k at February. Current year efficiency savings in Acute is £736k.
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	3 - Moderate
Risk level (current)	High Risk
Rating (current)	15
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	McKenna, Christopher
Handler	Reid, Euan
Previous Review Date	26/11/2021
Next Review	26/08/2022

NHS Fife

Meeting:	**Finance, Performance and Resource Governance Committee**
Meeting date:	**12 July 2022**
Title:	**NHS Fife Board Assurance Framework (BAF) Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance
- Approval

This report relates to a:

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

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

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

This report provides the committee with the next version of the NHS Fife BAF 5.

2.2 Background

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

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

The Committee is invited to consider the following:

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

2.3 Assessment

This BAF reflects the changes that have happened over the COVID period and includes the strategic planning for the new Population Health and Wellbeing Strategy for NHS Fife.

The current risk level is assessed as **Moderate**, the expectation is that as we progress through the milestone plan activity in terms of the new strategy development and, as the recently recruited additional PMO capacity embeds, that this risk level should reduce.

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

- the Strategic Priorities form the focus of strategic planning direction going forward for NHS Fife.
- Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. Engagement planning is ongoing and is being approached jointly with the HSCP as they develop the IJB Strategic Plan. This approach provides exciting opportunities to work collaboratively.
- The process for SPRA for 2022/23 has concluded with the production of a transitional organisational 1-year plan and financial plan. Corporate objectives have now been agreed by the Board in May 2022.
- The Annual Delivery Plan 22/23 is in development currently and the first draft will be shared at committee private sessions in July before submission at the end of July. The actions will be based on Scottish Government guidance, SPRA actions, carried over RMP4 actions and the Corporate Objectives.

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper was presented to EDG on 2 June 2022 in advance of discussion at other committees. Before coming to the committee, this paper has been to:

- Public Health and Wellbeing Committee, 4 July 2022

2.4 Recommendation

The committee is invited to:

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

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

NHS Fife Board Assurance Framework (BAF)

Board Assurance Framework (BAF) - Strategic Planning

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	08/06/2022	1 August 2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk	Director of Finance and Strategy Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 6/6/22 1. Board development session on strategy process was held in April 2022. 2. Strategy development ongoing with progress being made. Workshop planned with Public Health team to discuss DoPH report recommendations and alignment with Strategy. 3. Joint working on engagement of strategy and HSCP Strategic Plan over the next few months. 3. Corporate Objectives have been signed off by the Board	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting.	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed.	Corporate Objectives now finalised for 22/23. Annual Delivery Plan due to be submitted in July 22 using SPRA submissions. ADP/RMP4 Q1 update on deliverables to be submitted in July 22 with Q4 update submitted in April 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	Moderate Risk	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife

Meeting:	**Finance, Performance and Resource Committee**
Meeting date:	**12 July 2022**
Title:	**Board Assurance Framework – Environmental Sustainability**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Jimmy Ramsay, Estates Manager - Compliance**

1 Purpose

This is presented to Finance, Performance & Resources Committee for:

- Assurance
- Discussion
- Approval

This report relates to a:

- Board Governance & Strategic Objectives

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

- Safe
- Effective

2 Report Summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide assurances to this Committee and to the Board, that the organisation is delivering on its strategic objectives as they relate to environmental sustainability.

This report provides the committee with an update in relation to BAF risks.

The Internal Audit Internal Control Evaluation (ICE B08/22) Recommended that the risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy.

2.2 Background

Property & Asset Management receive capital funding from Scottish Government via NHS Fife's Capital Investment Group to address high risk statutory compliance or backlog maintenance issues. Prioritisation of this limited resource is carried out using a risk assessment methodology.

2.3 Assessment

The Environmental sustainability BAF remains as a **high** risk. Property & Asset Management continue to mitigate the identified risks.

Both PFI providers at St Andrews and the VHK have started the replacement programme for flexible hoses and these risks will be removed once these projects have been completed.

The Fire Evacuation Phase 2 linked risk remains at 15 following a review of the extensive mitigations undertaken last month.

The Theatre Phase 2 Remedial Works have been carried out as far as possible and this risk and the Fire Evacuation Phase 2 linked risk will remain as a residual risk until the commissioning of the new Fife Orthopaedic Elective Centre towards the end of 2022. Good progress is being made on site with respect to the new build.

The Director of Property & Asset Management and the NHS Fife Risk Manager are developing an appropriate risk which would aid and support the delivery of the future Health and Wellbeing Strategy as part of the corporate risk register which will replace the BAF as part of the overall review of risk management within NHS Fife. An additional risk with respect to environmental sustainability and net zero carbon targets is also being developed in line with DL (2021) 38 (a Policy for NHS Scotland on the Climate Emergency and Sustainable Development).

2.3.1 Quality/ Patient Care

There is no negative impact to patient care as the risks are being managed.

2.3.2 Workforce

N/A.

2.3.3 Financial

Projects are managed as and when funding becomes available through the capital planning process.

2.3.4 Risk Assessment/Management

Please see attached risks and BAF.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

External stakeholders are consulted where appropriate.

2.3.8 Route to the Meeting

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

- EDG 16 June 2022

2.4 Recommendation

The Committee is invited to:

- **Consider** the position set out above
- **Approve** the updated environmental sustainability element of the Board Assurance Framework

3 List of Appendices

The following appendices are included with this report:

- BAF Environmental Sustainability
- BAF Environmental Sustainability linked operational risks

Report Contact
Neil McCormick
Director of Property & Asset Management
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	06/06/2022	29 July 2022	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	McCormick, Neil
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	McCormick, Neil
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Low Risk	5	Wishart, James
735	Medical Equipment Register	Closed Risk	Moderate Risk	10	Lowe, David
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk	High Risk	15	Lowe, David
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk	High Risk	15	GRB
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk	Moderate Risk	10	Fairgrieve, Andrew
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk	Low Risk	6	Fairgrieve, Andrew
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk	Moderate Risk	8	BAN
1335	FCON Fire alarm potential faiure	Closed Risk	High Risk	15	GRB
1352	Pinpoint malfunction	Closed Risk	High Risk	16	Pirie, Margaret
1384	Microbiologist Vacancy	Closed Risk	High Risk	20	JGARDN
1473	Stratheden Hospital Fire Alarm System	Closed Risk	High Risk	20	Keatings, Gordon
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	McCormick, Neil

ID	1007	1252	1296
Position of Risk (Risk Register)	Acute Services - Planned Care - Theatres/Anaesthetics Risk Register	Corporate Directorate - Estates Risk Register	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register
Opened	11/02/2015	02/06/2016	22/08/2016
Title	Theatre Phase 2 Remedial work	Flexible PEX hoses in PHASE 3 VHK	Emergency Evacuation, VHK Phase 2 Tower Block
Description	Risk of increased loss of service due to deteriorating fabric of building resulting in reduced ability to reach TTG targets.	AF 2/8/16 There is a risk to patient safety due to a legionella risk in phase 3 building. EFA DH (2010)03 stated that flexible hoses when used for the supply of potable water may have an enhanced risk of harboring Legionella bacteria and other harmful microorganisms.	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	4 - Likely - Strong possibility this could occur
Consequence (initial)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (initial)	High Risk	High Risk	High Risk
Rating (initial)	15	15	20
Current Management Actions	DL 16/05/22 - Reactive repairs, routine planned maintenance activities and re-validation of Theatre ventilation plant is continuing to be managed through the Estates Department. Construction of new Fife Elective Orthopaedic Theatre (National Treatment Centre)is progressing on programme. Planned completion late Oct 2022, with handover for operational use by end of 2022.	JR - 06/06/2022 - update from Equans that works are underway. Completion date to be advised	JR - 06/06/2022 - Works have started on the doors, completion now end of June.
Likelihood (current)	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance
Consequence (current)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (current)	High Risk	High Risk	High Risk
Rating (current)	15	15	15
Likelihood (Target)	1 - Remote - Can't believe this event would happen	2 - Unlikely - Not expected to happen - potential exists	1 - Remote - Can't believe this event would happen
Consequence (Target)	5 - Extreme	5 - Extreme	5 - Extreme
Risk level (Target)	Low Risk	Moderate Risk	Low Risk
Rating (Target)	5	10	5
Risk Owner	Cross, Murray	McCormick, Neil	McCormick, Neil
Handler	Lowe, David	Bishop, Paul	Ramsay, Jimmy
Previous Review Date	16/05/2022	06/06/2022	06/06/2022
Next Review	16/08/2022	30/09/2022	31/08/2022

NHS Fife

Meeting:	**Finance, Performance & Resource Committee**
Meeting Date:	**12 July 2022**
Title:	**Property & Asset Management Strategy 2021/22**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Ben Johnston, Head of Capital Planning & Project Director**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Information
- Assurance

This report relates to a:

- 2022 update of the Property and Asset Management Strategy

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

- Safe
- Effective
- Person Centered
- Sustainability

2 Report Summary

2.1 Situation

This document provides an update to FP&R on the 2021/22 Property & Asset Management Strategy (PAMS) as required by the State of the NHS Scotland Assets and Facilities Report (SAFR) Programme.

The timescales for completion of this strategy document are included in the paper.

2.2 Background

There is an annual requirement to provide a data response for the “State of the NHS Scotland Assets and Facilities Report (SAFR) Programme”. The data allows NHS Scotland Assure to establish a position regarding the NHS estate across Scotland. The data also

allows Boards to understand the position regarding their own estate which in turn allows a plan to be developed in the form of a Property and Asset Management Strategy (PAMS).

NHS Fife's PAMS has been developed in line with guidance (SHTN 00-02) and a conscious effort has been made this year to consolidate the PAMS document into a summary, hopefully providing a more meaningful understanding of the estate and future change plans linking to wider strategy.

NHS Fife's 2022 PAMS will be compiled by the Head of Capital Planning & Project Director with oversight and direction for the Director of Property and Asset Management.

2.3 Assessment

The SAFR data for 2021/22 has now been compiled and returned to NHS Scotland Assure on 27 June 2022. The data compiled is representative of NHS Fife's current position regarding property and assets and will feed into the first section of the PAMS document (where are we now)?

The PAMS document is now complete in draft requiring final inputs from stakeholders to conclude. It is anticipated that the PAMS document will be finalised for governance by the end of July 2022. This timescale is consistent with the timescales outlined in the Population Health & Wellbeing Strategy plan with these key supporting strategies being aligned with the development of the main strategy by November 2022

The proposed governance for the PAMS is as follows:

- FCIG – 27 July 2022
- PH&W Portfolio Board – 11 August 2022
- FP&R – 13 September 2022
- NHS Fife Board – 27 September 2022

2.3.1 Quality/ Patient Care

The PAMS is important in respect to quality and patient care as it sets out the current condition of the estate and how this might be changed to support patient care moving into the future. The PAMS does this by linking to NHS Fife's Population Health and Wellbeing Strategy and supporting strategic framework.

2.3.2 Workforce

In order to facilitate the ambitions of the Board and make change, resource will be required to deliver this whilst mitigating risk. The PAMS will set out resource requirements particularly from a Capital Planning and Sustainability perspective – these being two of the key pressure points currently.

2.3.3 Financial

A 10-year summary investment plan will be included within the report. This will be a projected summary with no specific commitment to funding from Scottish Government.

2.3.4 Risk Assessment/Management

The PAMS will set out key risks from an Estates, Facilities and Capital Planning perspective.

2.3.5 Equality and Diversity, including health inequalities

Not applicable – EQIA's are undertaken on a project-by-project basis.

2.3.6 Other impact

Not Applicable.

2.3.7 Communication, involvement, engagement and consultation

Estates, Facilities and Capital Planning provide enabling services to respond to clinical requirements. Therefore, projects and strategy cannot be undertaken by the directorate in isolation, it requires wide communication and engagement to enable positive and sustainable changes to be made in the estate.

2.3.8 Route to the Meeting

N/A – this paper is provided as an update on the development of the PAMS and proposed governance route for discussion.

3 Recommendation

For information and assurance. Support for timeline and proposed governance route.

4 List of appendices

N/A.

Report Contact
Neil McCormick
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NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 July 2022**
Title:	**Fife Capital Investment Group Report 2022/23**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to:

- Capital Expenditure Plan 2022/23

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The current forecast expenditure on the capital plan for 2022/23 is £24.837m. At the end of May 2022, a total of £1.595m has been incurred across the various approved capital schemes as shown in the table below. Appendix 1 provides greater detail of expenditure to the end of May against each individual capital scheme.

Capital Plan	Planned £000s	Spend to May £000s
Core Allocation	7,764	641
National Treatment Centre - Fife Orthopaedics	13,389	856
Kincardine Health Centre	856	50
Lochgelly Health Centre	1,228	49
QMH Theatres PH 2	1,500	0
Mental Health	100	0
Totals	**24,837**	**1,595**

2.2 Assessment

As in previous financial years, capital expenditure is largely incurred in the second half of the financial year. At this time in the year no significant risks are being identified but national risks do remain with supply chain issues, high inflation and continued covid impacts.

Included in the Board's core allocation of £0.641m is spend on statutory compliance of £0.479m, equipment spend of £0.088m and digital spend of £0.073m. Although spend is still largely to be incurred, all three groups with responsibility for managing the core allocation budget have committed their respective allocations. Moreover, additional funding of £1.5m has recently been successfully secured from the National Infrastructure and Equipping Board to support various equipment replacement priorities not previously accommodated within the board core allocation for the financial year.

Work continues on the National Treatment Centre – Fife Orthopaedics with handover expected towards the end of October. Costs largely remain within budgeted levels with some increases due to the impact of the Covid pandemic. These costs were notified to Scottish Government Colleagues at the end of March.

The Outline Business Cases for Lochgelly and Kincardine Health Centres were discussed at the Scottish government's Capital Investment Group in June 2022, we await formal feedback from this session. As is the case with all major capital projects, SCIG will require completion of the NHS Assure process before approval can be given. A letter is anticipated from SCIG recommending the board continues to progress to Full Business Case but will note the NHS Assure process requires to be completed and funding confirmation would follow at a later stage.

At its June meeting, FCIG received 5-year capital plans covering the period 2022/23 to 2026/27 from the Capital Equipment Management Group, Digital and Information and Property and Infrastructure. The plans were well received and provided sufficient detail to support both the development of the in-year and medium-term capital expenditure plan.

2.2.1 Quality/ Patient Care

There is a potential risk to patient care if there are delays in upgrading buildings and replacement of equipment due to insufficient available funds.

2.2.2 Workforce

The prioritisation of capital to secure safe and effective working environments for our staff and patients supports health and wellbeing.

2.2.3 Financial

The appropriate prioritisation of capital to meet our corporate objectives is a key aim of the SPRA process.

2.2.4 Equality and Diversity, including health inequalities

All capital schemes follow the appropriate equality and diversity impact assessment process.

2.2.5 Other impact

n/a

2.3.6 Communication, involvement, engagement and consultation

All capital schemes require appropriate communication and engagement through the FCIG subgroups and specific project groups for particular schemes.

2.3.7 Route to the Meeting

Fife Capital investment group 9 June 2022

2.3 Recommendation

This paper is presented to the Committee for **assurance**.

3 List of appendices

Appendix 1 Capital Programme 2022/23

Report Contact

Maxine Michie
Deputy Director of Finance
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Appendix 1

NHS FIFE - CAPITAL BUDGET 2022/23
CAPITAL PROGRAMME EXPENDITURE REPORT - MAY 2022

Project	CRL New Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2022/23 £'000	Projected Variance £'000
Statutory Compliance				
Balance	**160,191**		**160,191**	
VHK Hospice	285,000	1,423	285,000	
VHK Steam 4b	1,350,000	471,480	1,350,000	
QMH PH2 Lift	180,000		180,000	
QMH Render Repairs	75,000		75,000	
Anti-Ligature Lomond Ward	82,212	2,252	82,212	
Anti-Ligature Ravenscraig	48,860	1,113	48,860	
Site LED Lighting Upgrades	12,000		12,000	
Window Replacements WBH	100,000		100,000	
WMB Roofs	102,737	2,973	102,737	
Total Statutory Compliance/Backlog Maintenance	**2,396,000**	**479,240**	**2,396,000**	
Clinical Prioritisation Contingency				
Balance	**250,000**		**250,000**	
Total Clincial Prioritisation	**250,000**		**250,000**	
Capital Equipment				
Capital Equipment Balance	**262,920**		262,920	
Specialist Bed	8,068		8,068	
Astral Ventilator	6,000		6,000	
Audiology Equipment	639	639	639	
CT Scanner Turnkey Works	217,000	72,846	217,000	
Dental Chair	15,783	426	15,783	
Digital Pathology Equipment	90,000		90,000	
DTC Stirrups	5,980	5,970	5,980	
General X-Ray Rooms * 3	760,000		760,000	
Micro Torque	8,232	8,154	8,232	
Treadmill	32,377	78	32,377	
Condemned Equipment				
Balance	**86,656**		86,656	
MRI PatientTrolley	7,356		7,356	
Ultrasound Probe	5,988		5,988	
Total Capital Equipment	**1,507,000**	**88,113**	**1,507,000**	
Digital & Information				
Balance	**803,826**		**803,826**	
Trackcare	73,174	73,174	73,174	
Total Digital & Information	**877,000**	**73,174**	**877,000**	
QMH Theatre Upgrades				
QMH Theatre Upgrades	**734,000**		**734,000**	
Total QMH Theatre Upgrades	**734,000**		**734,000**	
Capital to Revenue Transfer	**2,000,000**		**2,000,000**	
Elective Orthopaedic Centre	**856,030**	856,030	**856,030**	
Lochgelly Health Centre	**48,902**	48,902	**48,902**	
Kincardine Health Centre	**49,928**	49,928	**49,928**	
Mental Health Review				
TOTAL ALLOCATION FOR 2022/23	**8,718,860**	**1,595,387**	**8,718,860**	

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 July 2022**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to the:

- Integrated Performance & Quality Report

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report informs the Finance, Performance & Resources (FPR) 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 April 2022.

The initial version of the June report (sent to the CG and PHW Committees following EDG on 16 June), did not include any financial information.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board. It is produced monthly and made available to Board Members via Admin Control.

The report is presented at the meetings of the Clinical Governance, Staff Governance, Finance, Performance & Resources and Public Health & Wellbeing Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

Following the Active Governance workshop held on 2 November 2021, a review of the current Integrated Performance and Quality Report (IPQR) commenced by the establishment of a IPQR review group.

Following the workshop, a new Public Health & Wellbeing section was incorporated previously with the report now including Statistical Process Control (SPC) charts for applicable indicators. Following review, the list of indicators has been amended with further additions relating to Adverse Events, Immunisations and PDPR to follow in due course. Improvement actions will also be included following finalisation of Annual Delivery Plan for 2022/23.

2.3 Assessment

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. NHS Fife worked according to the Joint Fife Remobilisation Plan for 2021/22 (RMP4), and will now progress to incorporate the targets and aims of the 2022/23 Annual Delivery Plan (ADP), which is currently being finalised before being submitted to the Scottish Government at the end of July.

The FPR aspects of the report cover Operational Performance (in Acute Services/Corporate Services) and Finance. All measures apart from the two associated with Dementia PDS have performance targets and/or standards, and a summary of these is provided in the tables below.

WT = Waiting Times
RTT = Referral-to-Treatment
TTG = Treatment Time Guarantee (measured on Patient Waiting, not Patients Treated)
DTT = Decision-to-Treat-to-Treatment

Operational Performance – Acute Services / Corporate Services

Measure	Update	Target	Current Status
IVF WT	Monthly	100%	Achieving
4-Hour Emergency Access	Monthly	95%	Not achieving
New Outpatients WT	Monthly	95%	Not achieving
Diagnostics WT	Monthly	100%	Not achieving
Patient TTG	Monthly	100%	Not achieving
18 Weeks RTT	Monthly	90%	Not achieving
Cancer 31-Day DTT	Monthly	95%	Achieving
Cancer 62-Day RTT	Monthly	95%	Not achieving
Detect Cancer Early	Quarterly	29%	Not achieving
FOI Requests	Monthly	85%	Achieving

Finance

Measure	Update	Forecast	Current Status
Revenue Resource Limit	Monthly	£10.4m Overspend Projected	Financial Plan submitted to SG with resubmission due end July – overspend position remains as forecast.
Capital Resource Limit	Monthly	£24.9m	Achieving

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

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

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

The June IPQR will be available for discussion at the round of July Standing Committee meetings. As specified in Section 2.1, above, the CG and PHW Committees received a version of the report which did not include financial information. The full report is available to the FPR and SG Committees.

2.3.8 Route to the Meeting

The IPQR (less Financials) was ratified by EDG on 16 June, and approved for release by the Director of Finance & Strategy. The update (including Financials) was similarly approved for release after EDG on 7 July.

2.4 Recommendation

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

3 List of appendices

- IPQR

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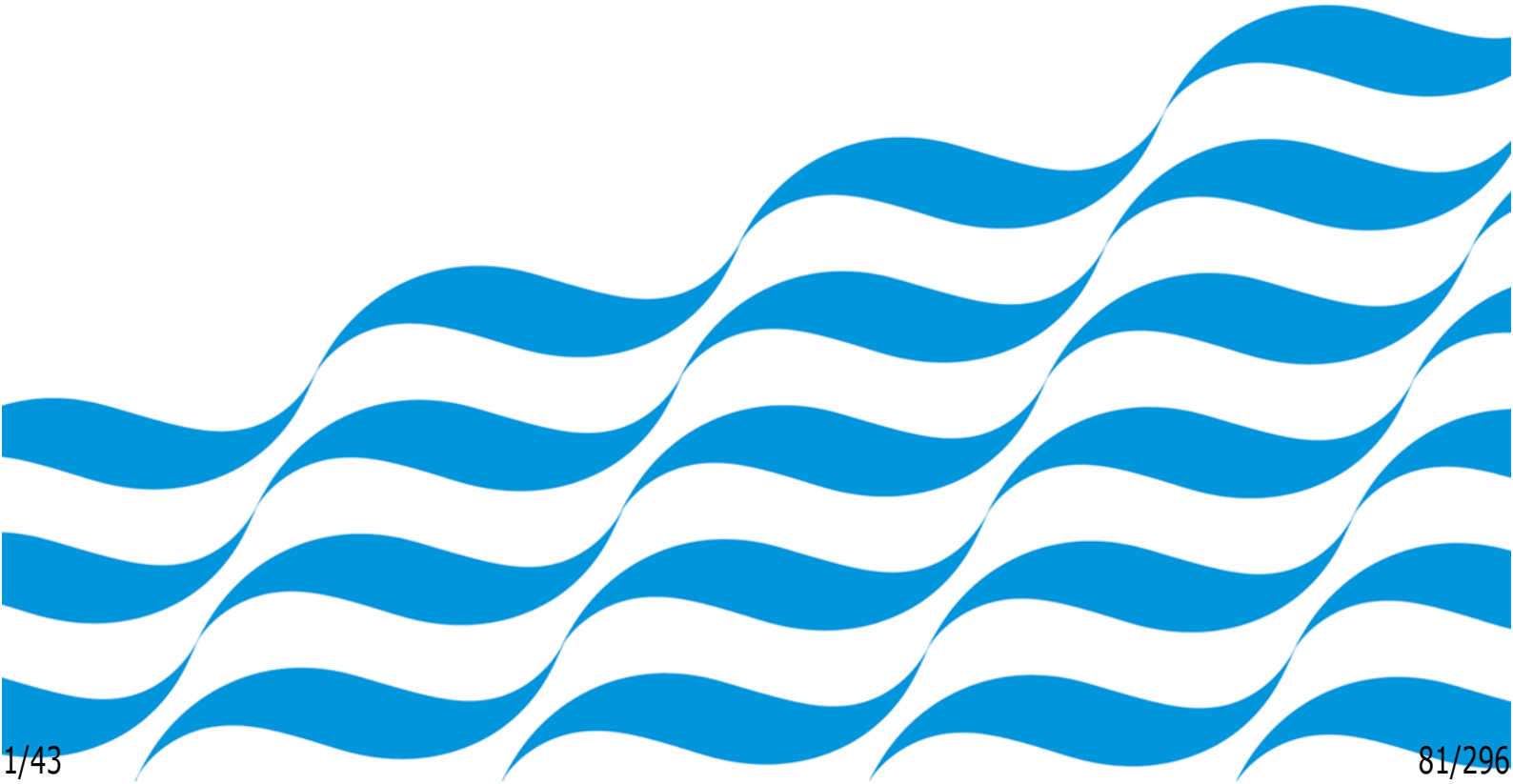
Fife Integrated Performance & Quality Report

Produced in June 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).

A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

The IPQR comprises of the following sections:

I. Executive Summary

a. National Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Projected & Actual Activity

e. Assessment

II. Performance Assessment Reports

a. Clinical Governance

b. Finance, Performance & Resources
   Operational Performance
   Finance

c. Staff Governance

d. Public Health & Wellbeing

Section II provides further detail for indicators of continual focus or those that are currently experiencing significant challenge. Each 'drill-down' contains further data presented in tables and charts, incorporating Statistical Process Control (SPC) methodology where applicable. Improvement actions will be sourced from Annual Delivery Plan and will be incorporated into the report in due course.

Statistical Process Control (SPC) techniques 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 focusses on the 'outlier' rule identifying whether a data point exceeds the calculated upper or lower control limits.

MARGO MCGURK
Director of Finance & Strategy
7 July 2022

Prepared by:
SUSAN FRASER
Associated Director of Planning & Performance

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against National Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current performance, comparison with 'previous' and 'previous year' and a benchmarking indication against other mainland NHS Boards (where appropriate). There is also an indication of 'special cause variation' based on Statistical Process Control methodology.

Amendments have been made to the IPQR following the IPQR Review. This involves the addition of some key indicators, removal of other indicators, updating of the Indicator Summary and data presented in SPC charts where appropriate. The Risk section will be introduced in the next few months.

NHS Boards are currently developing an Annual Delivery Plan (ADP) for 2022/23 to articulate the ongoing recovery of services following the COVID-19 Pandemic. Once agreed, actions relevant to indicators within IPQR will be incorporated accordingly and updated routinely to report to Standing Committees, Board and the Scottish Government.

a. LDP Standards & Key Performance Indicators

The performance status of the 27 indicators within this report which currently have agreed targets is 7 (26%) classified as **GREEN**, 5 (19%) **AMBER** and 15 (55%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits (mostly 5%) of standard/trajectory or considerably below standard/trajectory. The indicator 4-hour Emergency Access is displaying 'special cause variation' for April based on data for past 24 months with performance of 77.5% exceeding lower control limit.

Note that the RAG status of the two Finance measures is not available this month.

There were notable improvements in the following areas in April:

- Rate of falls of all Inpatients continuing a downward trend towards the new target for FY 2022/23
- % bed days lost due to patients in delay continuing a downward trend towards target
- Sickness Absence rate at its lowest monthly level since April 2021

Additionally, it has now been a full 2 years since the Cancer-31 DTT performance fell below the 95% Standard.

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). This benchmarking information indicates that whilst a number of areas continue to experience significant levels of challenge, in 90% where we are able to compare our performance nationally (20 out of 22 measures) we are delivering performance within either the upper quartile or the mid-range.

c. Indicator Summary

Section	Measure	Target 2022/23	Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Trend	Benchmarking
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Apr-22	24		▲	▲		
	HSMR	N/A	Year Ending	Dec-21	1.02		▲	▼		YE Dec-21
	Inpatient Falls	6.91	Month	Apr-22	7.09		▲	▲		
	Inpatient Falls with Harm	1.65	Month	Apr-22	1.81		▲	▼		
	Pressure Ulcers	0.89	Month	Apr-22	0.94		▲	▲		
	SAB - HAI/HCAI	18.8	Month	Apr-22	17.6		▼	▼		QE Dec-21
	C Diff - HAI/HCAI	6.5	Month	Apr-22	7.0		▼	▲		QE Dec-21
	ECB - HAI/HCAI	33.0	Month	Apr-22	28.1		▲	▼		QE Dec-21
	Complaints Closed - Stage 1	80%	Month	Apr-22	72.7%		▲	▼		2020/21
	Complaints Closed - Stage 2	50%	Month	Apr-22	5.9%		▼	▼		2020/21
Operational Performance	IVF Treatment Waiting Times	90%	Month	Apr-22	100.0%		◀▶	◀▶		
	4-Hour Emergency Access	95%	Month	Apr-22	77.5%	○	▼	▼		Apr-22
	Patient TTG % <= 12 Weeks	100%	Month	Apr-22	55.9%		▲	▲		Mar-22
	New Outpatients % <= 12 Weeks	95%	Month	Apr-22	53.9%		▲	▼		Mar-22
	Diagnostics % <= 6 Weeks	100%	Month	Apr-22	63.0%		▲	▼		Mar-22
	18 Weeks RTT	90%	Month	Apr-22	70.4%		▲	▲		QE Mar-22
	Cancer 31-Day DTT	95%	Month	Apr-22	98.0%		▲	▲		QE Dec-21
	Cancer 62-Day RTT	95%	Month	Apr-22	84.9%		▲	▲		QE Dec-21
	Detect Cancer Early	29%	Year Ending	Sep-21	23.2%		▲	▲		2019, 2020
	Freedom of Information Requests	85%	Month	Apr-22	97.6%		▲	▲		
	Delayed Discharge % Bed Days Lost (All)	N/A	Month	Apr-22	12.0%		▼	▲		QE Dec-21
	Delayed Discharge % Bed Days Lost (Standard)	5%	Month	Apr-22	6.5%		▲	▲		QE Dec-21
	Antenatal Access	80%	Month	Mar-22	82.1%		▼	▼		CY 2021
Finance	Revenue Resource Limit Performance	(£10.4m)	Month	May-22	(£5.4m)		—	—		
	Capital Resource Limit Performance	£24.8m	Month	May-22	£1.6m		—	—		
Staff Governance	Sickness Absence	4.00%	Month	Apr-22	5.14%		▲	▼		YE Mar-22
Public Health & Wellbeing	Smoking Cessation (FY 2021/22)	473	YTD	Feb-22	288		—	▲		QE Sep-21
	CAMHS Waiting Times	90%	Month	Apr-22	71.1%		▲	▲		QE Mar-22
	Psychological Therapies Waiting Times	90%	Month	Apr-22	76.5%		▼	▼		QE Mar-22
	Drugs & Alcohol Waiting Times	90%	Month	Feb-22	89.3%		▲	▼		QE Dec-21

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

○ Special cause variation, out with control limits

Change Key

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

Benchmarking Key

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

d. Projected and Actual Activity

Better than Projected | Worse than Projected | No Assessment

(NOTE: Better/Worse may be higher or lower, depending on context)

		Month End			Quarter End	Quarter End	Quarter End	Quarter End
		Apr-22	May-22	Jun-22	Jun-22	Sep-22	Dec-22	Mar-23
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	1,012	1,012	1,012	3,036	3,053	3,087	3,087
	Actual	816	1,087		1,903	0	0	0
	Variance	-196	75		-1,133	-3,053	-3,087	-3,087
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	6,180	6,186	6,201	18,567	18,806	19,132	19,166
	Actual	6,036	7,603		13,639	0	0	0
	Variance	-144	1,417		-4,928	-18,806	-19,132	-19,166
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	497	497	497	1,491	1,491	1,491	1,491
	Actual	460	543		1,003	0	0	0
	Variance	-37	46		-488	-1,491	-1,491	-1,491
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	3,996	3,996	3,996	11,988	11,988	11,988	11,988
	Actual	4,759	4,486		9,245	0	0	0
	Variance	763	490		-2,743	-11,988	-11,988	-11,988

e. Assessment

CLINICAL GOVERNANCE		Target	Current
HSMR		**1.00**	**1.02**
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR that was observed in 2020 has subsequently reduced. Data for 2021 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**	**7.09**
Falls data/trends continue to be reviewed focussing on areas with higher incidence to support improvement work. The 2021/22 target (a rate of 7.68 falls per 1,000 Occupied Bed Days) was met but note the work required to drive this down. The new target reflects the ambition of SPSP to reduce falls by 30% by 2024 with the approach of a 10% reduction per year being envisaged. The Steering Group is currently updating the workplan to drive the activity toward this year's target for reduction. Imminent changes in Infection Control guidance is expected to reduce some of the environmental challenges that have presented over the last two years.			
Pressure Ulcers	*Reduce pressure ulcer rate by 25% in FY 2022/23 compared to the rate in FY 2021/22*	**0.89**	**0.94**
As we mobilise out of the pandemic and significant pressures continue across the system, the 25% reduction in pressure ulcers (grade 2 to 4) targeted for this FY is thought be achievable and stretching. Whilst the data continues to show a random pattern, there has been a favourable downward trend over the past 3 months, with the previous 2 months being below the median. ASD have seen a month-on-month reduction in harms over the past 3 months with HSCP seeing the same pattern over the past 2 months. The pressure ulcer report continues to be shared with clinical teams and is one data source used for triangulation in order to drive improvement. Clinical Teams continue to follow the process for Major and Extreme Adverse Events for shared learning.			
SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**18.8**	**17.6**
NHS Fife continues to address its SABs and is currently ahead of the trajectory to achieve the 10% reduction by March 2023. There was a single PVC SAB in March and there have been 3 PWID SABs in 2022 to date; positively, there has been no Renal haemodialysis line related SABs since October 2021.			
C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2023*	**6.5**	**7.0**
NHS Fife is on target to achieve the 10% reduction by March 2023 although there have been 10 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 2 recurrences of infection in 2022.			
ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2023*	**33.0**	**28.1**
NHS Fife is on target to achieve a 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 13 CAUTIs in 2022 to date.			
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%**	**5.9%**
There remain challenges in investigating and responding to Stage 2 complaints within the national timescales, primarily due to staffing and capacity issues across all services. We continue to see an increased volume of complaints, the majority being complex or covering multiple specialities/services. The Patient Relations team continues to face capacity and staffing levels, which have been exacerbated by vacancies and staff absence, some of which is long-term. This is having a negative effect on meeting timeframes, due to the increased workload on staff (who are managing multiple caseloads) and individual ability to manage day-to-day ad-hoc work. In order to address these challenges, existing processes have been reviewed in order to streamline workloads and generate efficiencies.			

OPERATIONAL PERFORMANCE		Target	Current
4-Hour Emergency Access	*95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer*	**95%**	**77.5%**

Attendance has continued to be high (a 4-week average of 223 daily attendances), impacting on the 4-hour access target. Escalation actions through OPEL, including additional surge capacity, remains in place within ASD and HSCP to accommodate the additional inpatient demand. The emergency department continue with plans for remodelling to allow for expanded assessment provision and a new approach to enhanced triage and redirection to QMH MIU is being reviewed.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**55.9%**

Performance in April has improved slightly. Day case elective activity increased in March due to additional waiting list initiatives, but inpatient surgery continues to be restricted to urgent and cancer patients due to sustained pressures in unscheduled care and COVID sickness absence. The waiting list continues to rise with 4,601 patients on list in April, 50% greater than in April 2021. There is a continued focus on clinical priorities whilst reviewing long waiting patients. A new recovery plan has been submitted to the Scottish Government and a decision is awaited around the additional resources needed to deliver additional capacity in the plan. No additional activity has been undertaken in April and core activity remains restricted.

New Outpatients	*95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment*	**95%**	**53.9%**

Performance in April has improved slightly following additional waiting list activity; however, core capacity remains restricted due to the ongoing need for physical distancing and the pressures of unscheduled care on outpatient capacity is some specialities. The waiting list has increased, with 22,594 on the outpatient waiting list, 12% higher than in April 2021. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks. The number waiting over 52 weeks has risen to 567 in March mainly in Gastroenterology, General Surgery and Vascular Surgery specialties. A new recovery plan has been submitted to the Scottish Government and a decision is awaited around the additional resources needed to deliver additional capacity in the plan. No additional activity has been undertaken in April. Following updated infection prevention and control guidance it is anticipated that there will be a reduction in the need for physical distancing. However, the impact of this will be monitored and sustaining the current level of activity is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from COVID.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**63.0%**

Performance improved slightly in April. The improvement has been in Radiology with 67.7% waiting less than 6 weeks whilst the performance in endoscopy has deteriorated to 42.8% of patients waiting less than 6 weeks. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. The overall waiting list for diagnostics has reduced in April to 5,714 although the number waiting for an Endoscopy has increased. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. A new recovery plan has been submitted to the Scottish Government and a decision is awaited around the additional resources needed to deliver additional capacity in the plan. It is anticipated that performance will continue to be challenged due to the demand for urgent diagnostics and the pressure from unscheduled care along with continued restrictions in activity due to enhanced infection control measures and staff absence due to COVID.

Cancer 62-Day RTT	*95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral*	**95%**	**84.9%**

April continued to see challenges, but there was a slight improvement in performance. The number of referrals remains high, consistently exceeding pre pandemic numbers. Breaches are attributed to COVID-19 staffing issues and lack of resources, with particular capacity issues in some specialties. Breast, Oncology and Urology (Prostate) are currently our most challenged pathways. Improvements are being made at the start of the latter to reduce waits between steps and improve patient experience. The range of breaches (majority in Prostate) was 2 to 34 days (average 13 days).

OPERATIONAL PERFORMANCE		Target	Current
Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay (excluding those marked as Code 9) is to reduce*	**5%**	**6.3%**

The number of bed days lost due to patients in delay continues to follow a downward trajectory following a spike in February, due largely to the significant covid wave the system has endured and subsequent demand pressures on H&SCP exits. Encouragingly, despite these pressures the position is only 1.3% over target 5%.

The H&SCP continues to operate with approximately 44 surge beds and regularly maintains occupancy levels above 110%. On top of this, referrals to the VHK Integrated Discharge hub have never been higher which is putting continued strain on community services. Despite this however we note that the latest Public Health Scotland Data (3rd May 2022) placed NHS Fife as having the lowest number of patients in delay per 100,000 Age 18+ population of the 11 Mainland Health Boards.

FINANCE		Forecast	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**(£10.4m)**	**(£5.4m)**

At the end of May the board's reported financial position is an overspend of £6.453m on Health Retained. This overspend comprises: £2.061m core overspend (of which £0.855m relates to Acute Set Aside overspend); £1.735m opening financial gap; and as yet unfunded Covid-19 costs of £2.657m (including £1.078m Public Health Test and Protect costs).

The Health Delegated position reflects a core underspend of £1.043m.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£24.8m**	**£1.6m**

The overall anticipated capital budget for 2022/23 is £24.837m. The capital position for the period to May records spend of £1.595m. Therefore, 6.42% of the anticipated total capital allocation has been spent to month 2. The full capital programme is expected to deliver in full with significant activity in the final month of the year working towards a balanced capital position.

STAFF GOVERNANCE		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**4.00%**	**5.14%**

The sickness absence rate in April was 5.14%, a reduction of 0.45% from the rate in March. The COVID-19 related special leave rate, as a percentage of available contracted hours for April, was 2.46%.

To ensure focus on this issue an Attendance Taskforce has been established which will facilitate actions and drive improvements to ensure NHS Fife works to achieve the sickness absence performance target.

Pending any additional NHS Scotland guidance on sickness absence targets, we continue to monitor absence against our existing target of 4%. We would anticipate that any national update will reflect the circumstances of the last two years and therefore this target may be subject to change.

PUBLIC HEALTH & WELLBEING		Target	Current
Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**288**

The service is moving into a transitional stage whereby we are using a hybrid approach by continuing to deliver an element of service provision remotely through telephone support while concurrently returning to face to face delivery in Linburn and North Glen GP practices and Lochgelly Community centre. In addition, the mobile unit has been in Cowdenbeath, Templehall and Glamis Centre to build up service awareness and to reach our more vulnerable communities. Successful quits are currently sitting at 288 with room for improvement before final verification at the end of June. A range of service awareness opportunities and benefits of quitting happened on No Smoking Day on 9th March which saw an uplift in referrals of 14% during that week.

CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**71.1%**

RTT performance has been maintained at the projected level as work on the longest waits continues. Urgent and priority referrals remain high with an increased proportion of staff activity allocated to young people presenting with Acute/High Risk presentations. The process to fill vacant posts continues with a total of 16 posts either in the recruitment process or out to advert across a range of professions that contribute to CAMHS. The longest wait initiative has been implemented through the offer of additional hours and reallocation of PMHW clinical capacity in order to re-align the current position with the predicted position which was negatively impacted by staff absence and cancelled appointments during January and February.

Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**76.5%**

The demand for PTs increased significantly in the latter half of 2021 compared to the first 6 months of that year and this remains the case in the first 4 months of 2022 so far. This has resulted in an increase in numbers on the waiting list. Issues of workforce availability have negatively impacted the increase in activity that was anticipated from October onwards.

II. Performance Exception Reports

Clinical Governance

Finance, Performance & Resources: Operational Performance

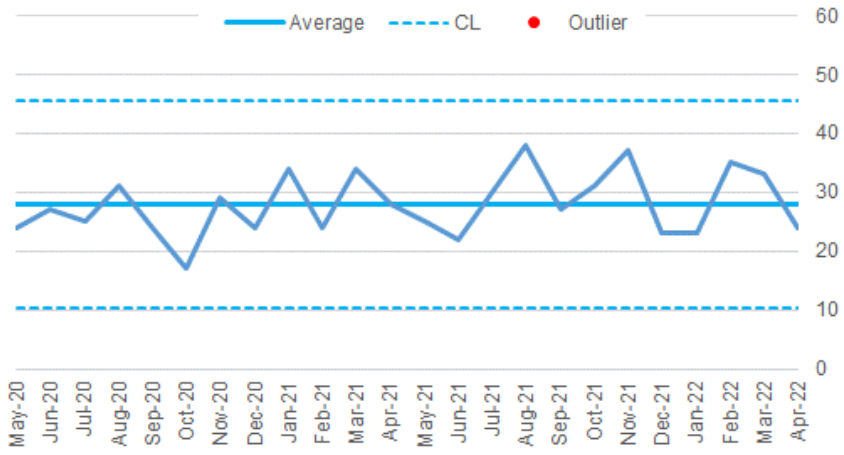
Finance, Performance & Resources: Finance

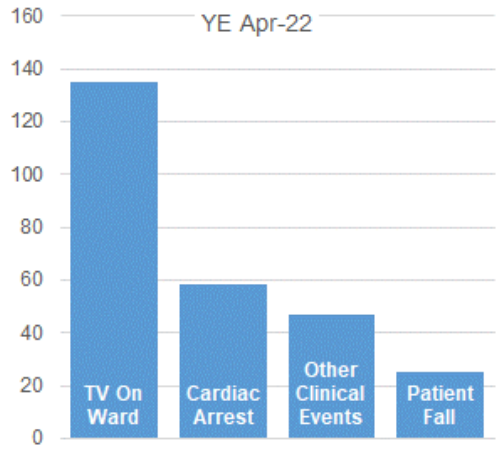
Staff Governance

Public Health & Wellbeing

Adverse Events

Major and Extreme Adverse Events





All Adverse Events

	Month	2021/22											2022/23
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
ALL	NHS Fife	1373	1352	1422	1455	1400	1397	1444	1497	1503	1289	1451	1202
	Acute Services	649	606	630	616	611	649	635	598	615	514	670	518
	HSCP	682	695	741	801	747	692	750	837	853	725	717	634
	Corporate	42	51	51	38	42	56	59	62	35	50	64	50
CLINICAL	NHS Fife	1012	937	1011	958	967	952	1020	973	945	898	1052	822
	Acute Services	600	547	569	551	538	569	584	538	569	463	616	474
	HSCP	388	366	412	386	402	353	407	396	361	406	399	328
	Corporate	24	24	30	21	27	30	29	39	15	29	37	20

Commentary

Incident numbers in March showed a slight increase, but decreased in April to the lowest level in the past 12 months; overall combined figures for the two month period is in keeping with monthly averages.

The sub category 'Transfer - In-Patient Transfer Problems' specifically relating to communication and delays, showed a significant increase in March. This sits within the 'Access / Appointment / Admission / Transfer or Discharge incidents' category, which is the only category showing any significant variation within March and April.

There were 30 Local Adverse Event Reviews and 6 Significant Adverse Event Reviews completed with formal sign off during March and April.

Focused improvement work continues in relation to falls, pressure ulcers and deteriorating patient. Adverse Events improvement work is ongoing. A dedicated Adverse Events resource folder has been created within Blink, and this holds resources to facilitate adverse events incident management as well as including links to human factors training. Collaborative work on the adverse events improvement plan is ongoing.

IMPROVEMENT ACTIONS

New improvement actions for will be incorporated following approval of Annual Delivery Plan

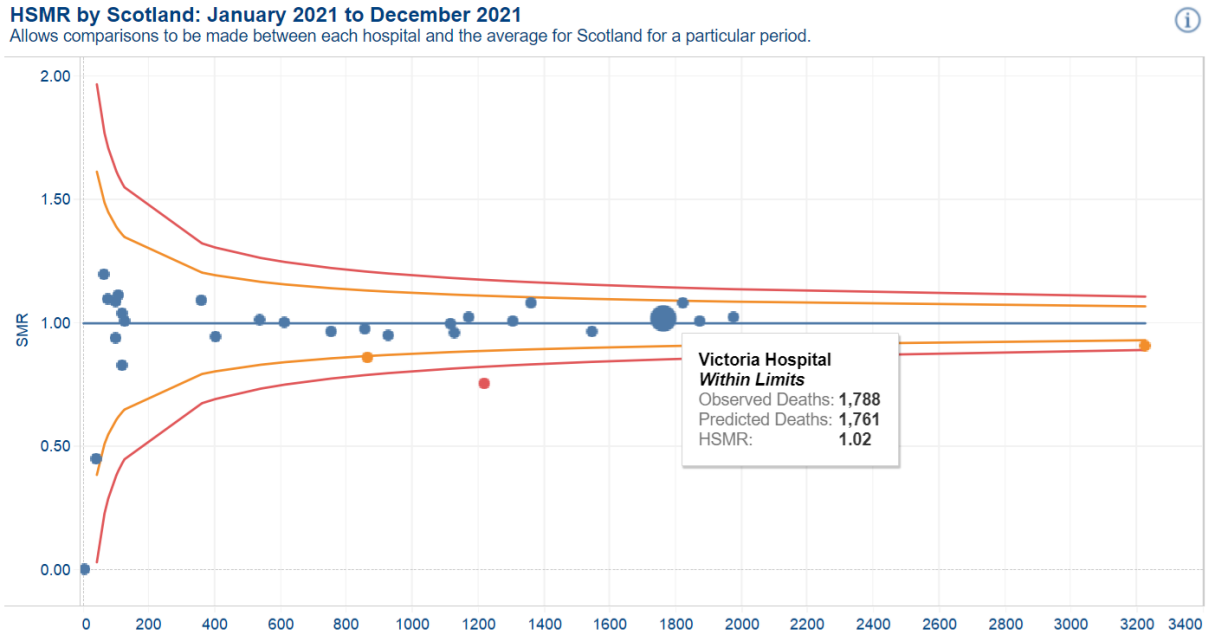
HSMR

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

Reporting Period; January 2021 to December 2021[p]

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

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



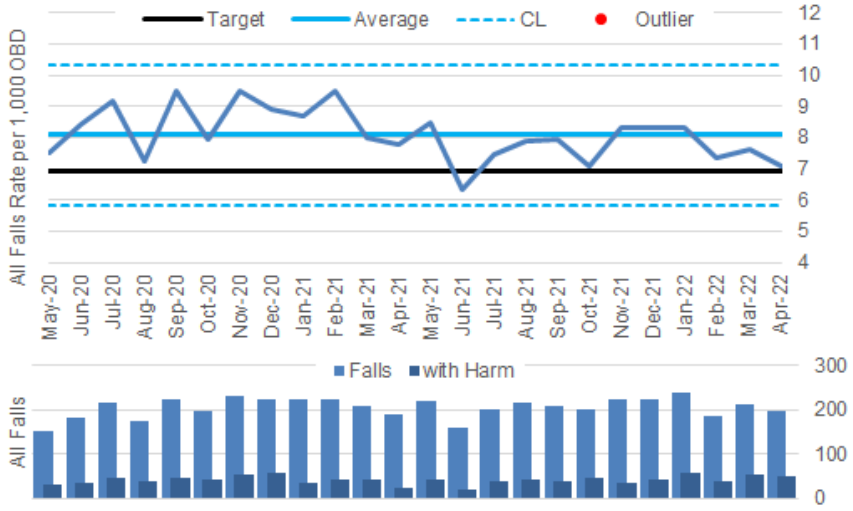
Commentary

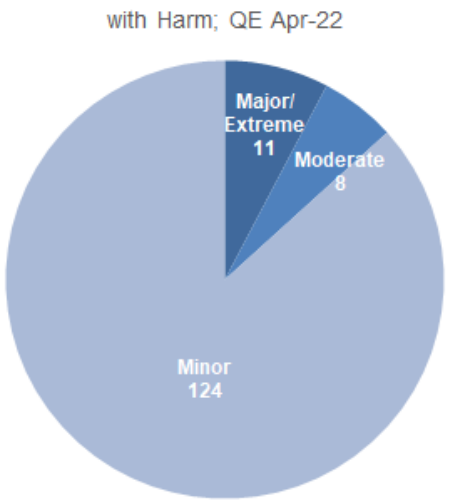
Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR that was observed in 2020 has subsequently reduced. Data for 2021 demonstrates a return to a typical ratio for NHS Fife.

Inpatient Falls

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

Local Performance





Performance by Service Area

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	8.45	6.32	7.45	7.88	7.93	7.08	8.32	8.29	8.33	7.33	7.62	7.09
Acute Services	8.38	6.14	7.17	8.17	7.61	8.51	8.71	8.55	9.47	7.55	7.18	8.17
HSCP	8.52	6.47	7.70	7.63	8.21	5.85	7.97	8.06	7.34	7.16	8.01	6.14

IMPROVEMENT ACTIONS

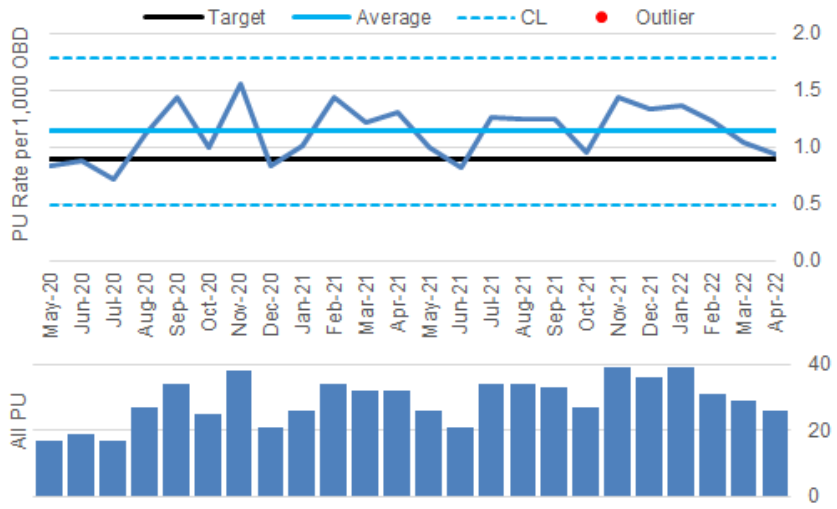
20.3 Falls Audit	***By Aug-22***
As part of the work plan update there will be an annual audit programme set which will include the Care and Comfort Clock Audit and the Falls Intervention Plan	
20.5 Improve effectiveness of Falls Champion Network	***By Aug-22***
This work remains on hold due to staffing challenges, with contact being maintained with existing champions. This work will remain a focus in the forthcoming work plan.	

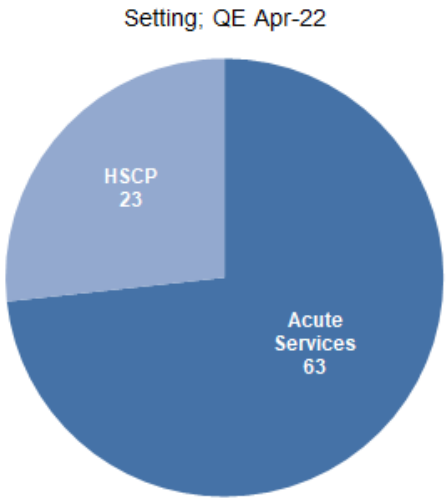
New improvement actions for will be incorporated following approval of Annual Delivery Plan

Pressure Ulcers

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

Local Performance





Performance by Service Area

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	0.99	0.82	1.26	1.25	1.24	0.95	1.44	1.33	1.36	1.23	1.03	0.94
Acute Services	1.60	1.58	2.13	2.36	2.10	1.44	2.54	2.24	2.25	1.84	1.76	1.45
HSCP	0.44	0.15	0.49	0.27	0.49	0.53	0.49	0.55	0.58	0.72	0.40	0.48

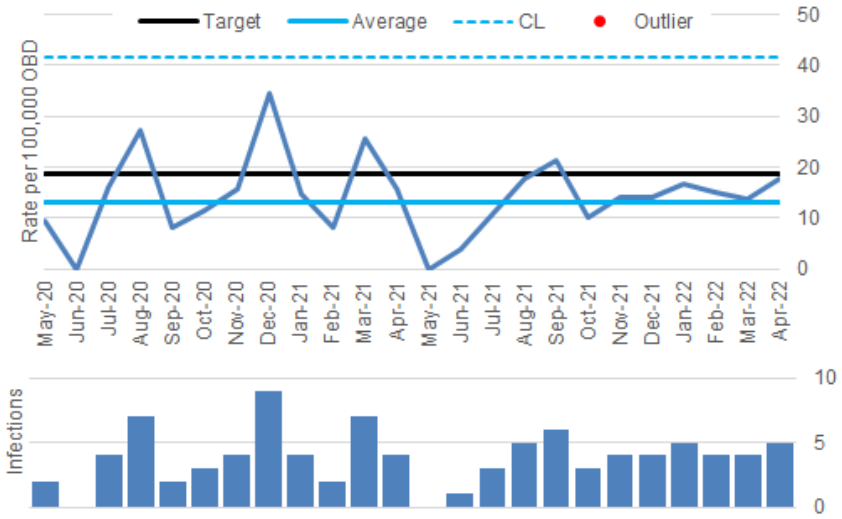
IMPROVEMENT ACTIONS

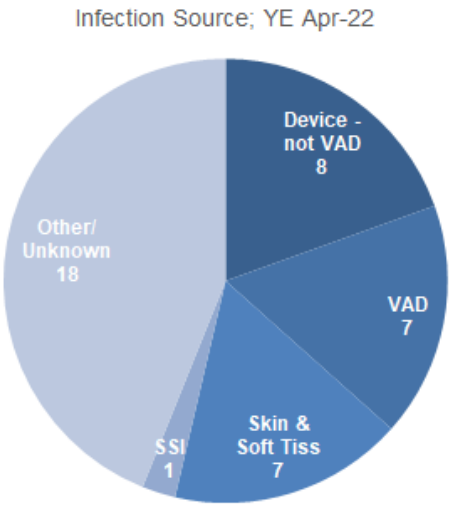
New improvement actions for will be incorporated following approval of Annual Delivery Plan

SAB (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	6.3	18.7	20.6	17.8	6.3	16.6	12.8
Scotland	20.3	17.3	18.9	18.4	18.6	18.3	17.3

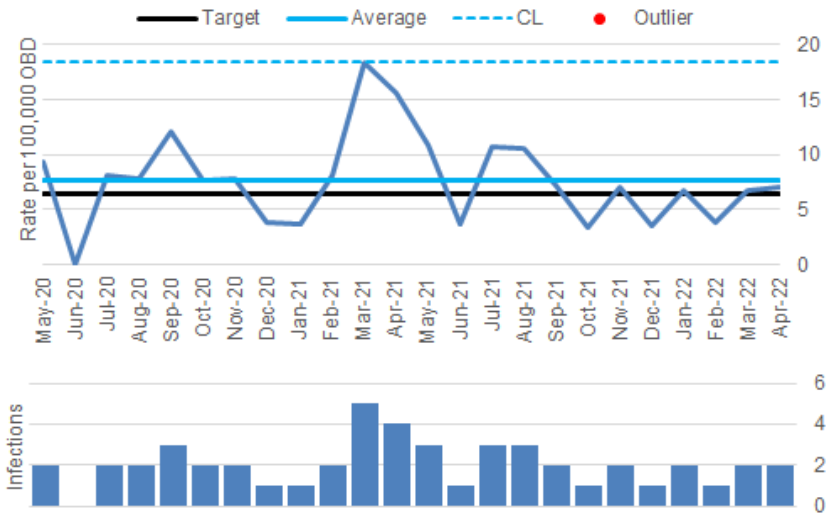
IMPROVEMENT ACTIONS

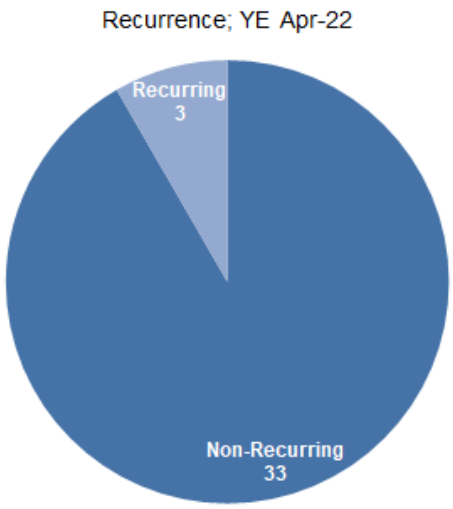
New improvement actions for will be incorporated following approval of Annual Delivery Plan

C Diff (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	7.9	9.3	7.7	14.0	10.0	9.5	4.6
Scotland	15.4	17.4	16.4	15.8	14.6	16.8	13.3

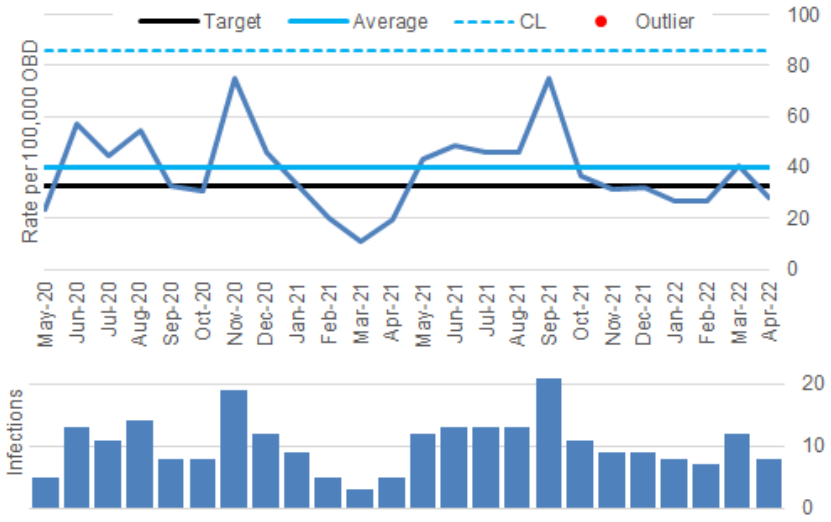
IMPROVEMENT ACTIONS

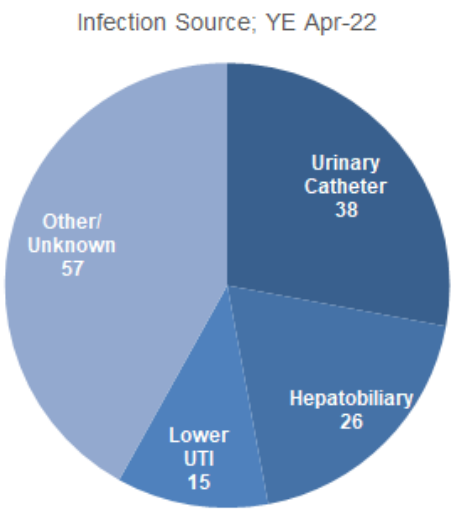
New improvement actions for will be incorporated following approval of Annual Delivery Plan

ECB (HAI/HCAI)

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

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	36.4	45.3	50.3	21.6	37.6	60.3	33.6
Scotland	39.7	42.0	40.9	34.7	38.2	41.4	34.1

IMPROVEMENT ACTIONS

20.1 Optimise communications with all clinical teams in ASD & the HSCP	***By Mar-24***

Monthly ECB reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB undergoes IPC surveillance and a DATIX is submitted for all catheter associated ECBs, prompting an LAER by the patient`s clinical team.
NHS Fife is currently on target for achieving the 25% target reduction by the end of March 2023; a further 25% reduction of HCAI ECBs is to be achieved by March 2024.

20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG)	***By Mar-24***

The UCIG meeting met in May, when initiatives to promote hydration and provide optimum urinary catheter care (including continence care) across Fife were discussed. They cover analysis and update of process, training/education/promotion and quality improvement work.

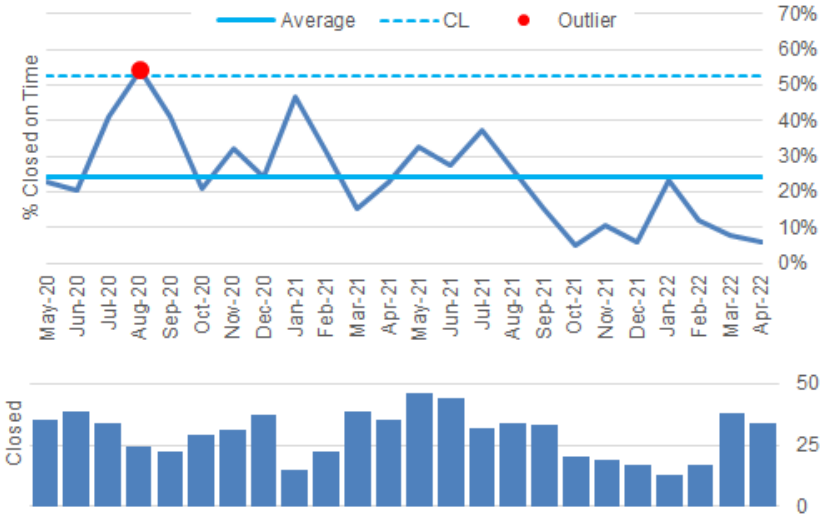
A new eCatheter insertion & maintenance bundle on Patientrack is due to be trialled by Urology before being rolled out across the wards within the ASD & HSCP. This will ensure optimum catheter care is delivered across NHS Fife resulting in a reduction of CAUTIs within the hospital setting.

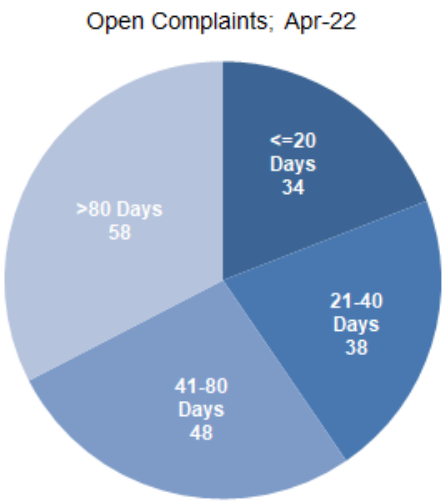
New improvement actions for will be incorporated following approval of Annual Delivery Plan

Complaints | Stage 2

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

Local Performance





Performance by Service Area

		2021/22											2022/23
		MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	% Closed on Time	32.6%	27.3%	37.5%	26.5%	15.2%	5.0%	10.5%	5.9%	23.1%	11.8%	7.9%	5.9%
	% Acknowledged (3 days)	93.5%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	88.2%	84.6%	100.0%	89.5%	88.2%
Acute Services	% Closed on Time	23.3%	21.4%	26.1%	31.6%	21.7%	0.0%	16.7%	7.7%	30.0%	18.2%	3.6%	8.0%
HSCP	% Closed on Time	53.8%	16.7%	50.0%	16.7%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%

IMPROVEMENT ACTIONS

22.1 Review complaint handling process and agree measures to ensure quality — **By Sep-22**

An overall review of the existing complaints handling process by Quality Improvement and Patient Relations teams continues, with a new digital monitoring system in development. This will significantly reduce duplication and negate the need for manual counting to ascertain complaints status.

In March, the Patient Relations Team focused on clearing their backlog of complaints, which was successful in reducing these numbers considerably; however, this has steadily increased again and we once more face a significant backlog of cases requiring drafting and/or progression. This is due to the ongoing increase in complaint numbers, as well as current staffing challenges.

However, the Patient Relations team have recently taken on several temporary staff members from the Contact Tracing team, who are currently receiving training in complaints handling, with a focus on stage 2 response drafting. The aim is for these additional staff members to support the Patient Relations Officers with drafting, which will help to reduce and maintain the number of cases waiting to be drafted, as well as helping to manage overall caseloads.

A new Head of Patient Experience has been appointed to the lead team and will commence in July 2022. The team will be re-branded as the Patient Experience Team and will not only focus on complaints handling (once all backlogs are cleared) but will also proactively lead on obtaining realtime patient feedback to improve patient experience and reduce complaints moving forwards.

22.2 Improve education of complaint handling — **By Sep-22**

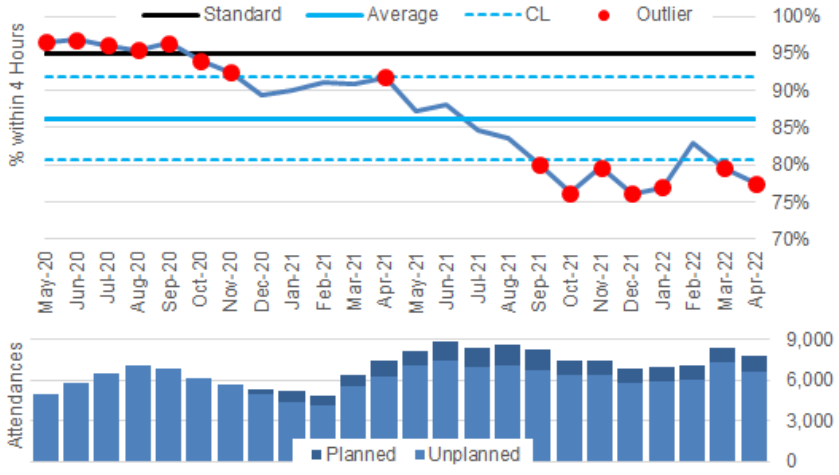
There is an existing aim to improve overall quality by recommencing the delivery of education programmes, such as induction and bespoke training sessions, across all Clinical Services. However, this plan remains on hold at present due to the pressures and capacity within the team as well as the ongoing response to COVID-19. Patient Relations is engaging with the Organisational Learning Group to share learning from complaints, address common themes and target improvements.

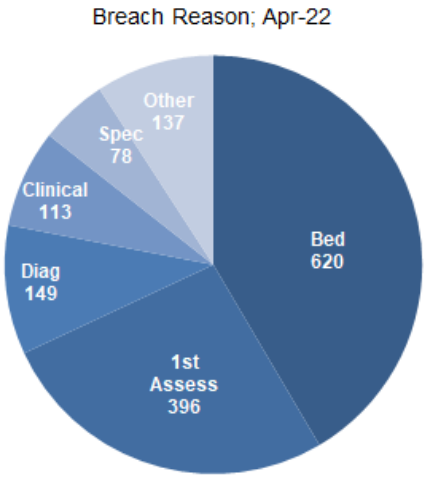
New improvement actions for will be incorporated following approval of Annual Delivery Plan

4-Hour Emergency Access

At least 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident & Emergency treatment

Local Performance





National Benchmarking

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	87.2%	88.2%	84.7%	83.6%	80.1%	76.3%	79.7%	76.1%	77.0%	83.0%	79.6%	77.5%
Scotland	87.2%	85.1%	81.5%	77.8%	76.1%	73.5%	75.9%	75.7%	76.0%	74.2%	71.6%	72.1%

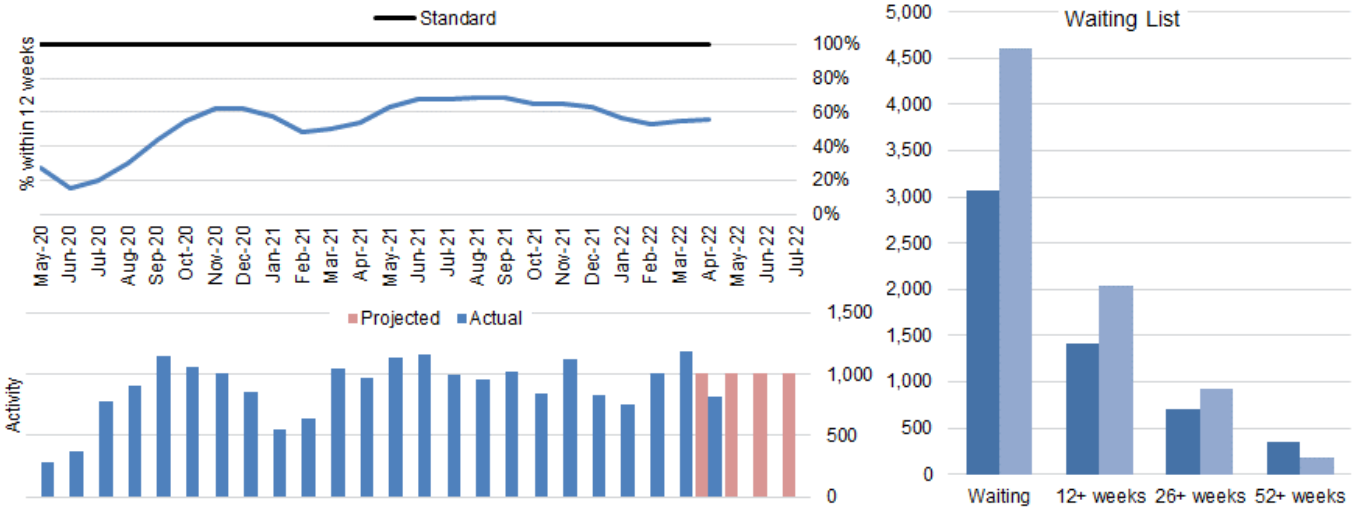
IMPROVEMENT ACTIONS

New improvement actions for will be incorporated following approval of Annual Delivery Plan

Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

Local Performance



National Benchmarking

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	62.7%	67.9%	67.6%	68.2%	68.2%	64.9%	65.1%	63.1%	56.6%	52.7%	55.2%	55.9%
Scotland	37.2%	38.6%	36.7%	36.5%	34.0%	37.5%	37.3%	34.6%	33.7%	32.5%	34.0%	

IMPROVEMENT ACTIONS

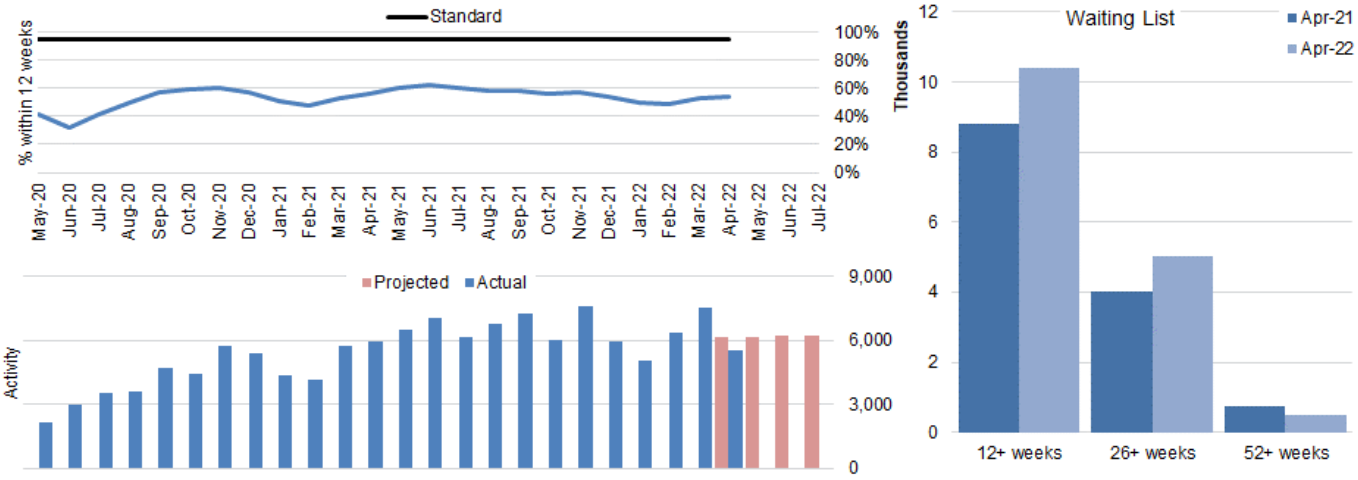
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Sep-22**
Business case being progressed suitable IT system identified	

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance



National Benchmarking

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	60.3%	62.4%	60.7%	58.6%	58.3%	56.5%	57.1%	53.8%	50.1%	48.8%	53.4%	53.9%
Scotland	52.3%	53.4%	51.6%	49.7%	48.1%	48.0%	48.4%	46.5%	45.5%	45.9%	49.6%	

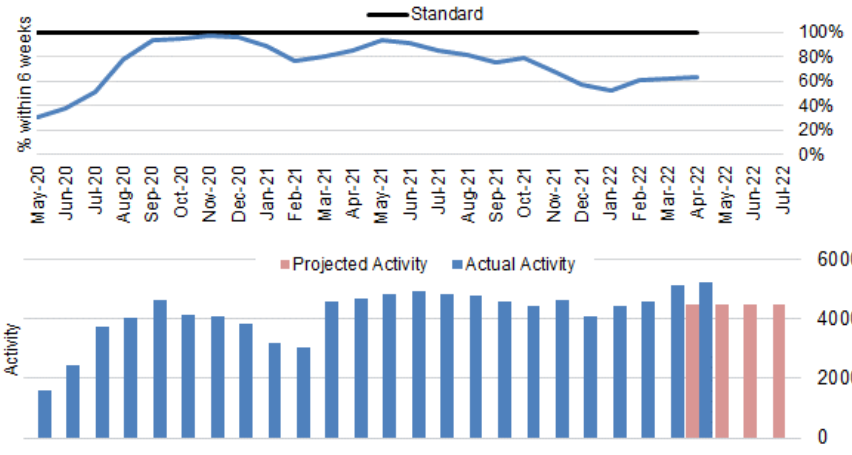
IMPROVEMENT ACTIONS

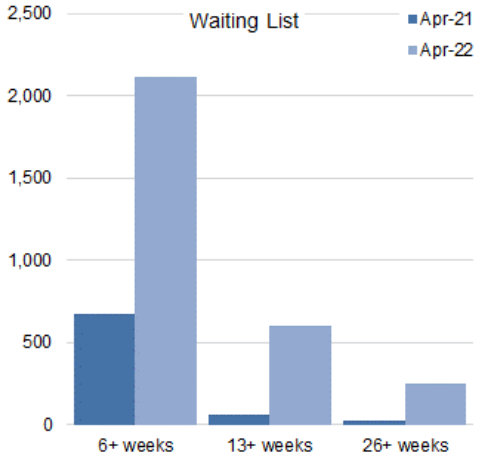
New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Diagnostics Waiting Times

No patient will wait more than 6 weeks to receive one of the 8 Key Diagnostics Tests appointment

Local Performance





National Benchmarking

	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	93.5%	90.6%	84.9%	81.2%	75.7%	78.7%	68.3%	57.8%	52.7%	61.2%	61.6%	63.0%
Scotland	64.1%	62.6%	57.2%	56.5%	57.8%	55.2%	56.9%	49.6%	48.1%	50.8%	49.6%	

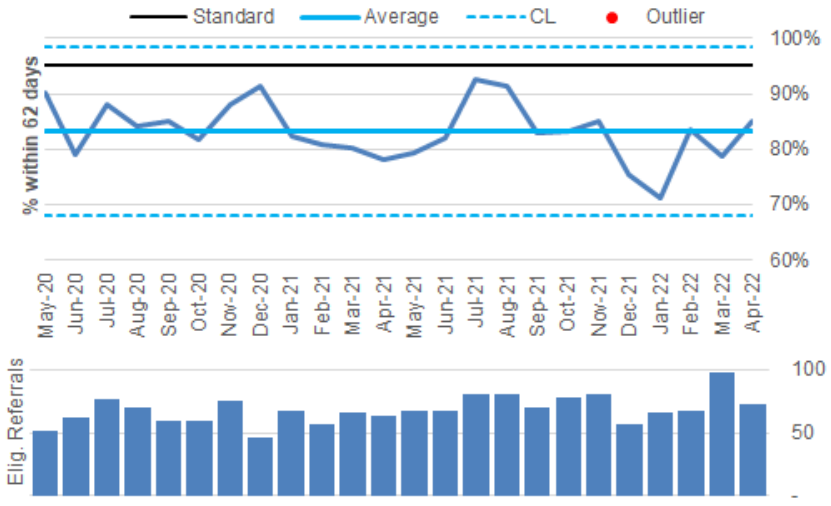
IMPROVEMENT ACTIONS

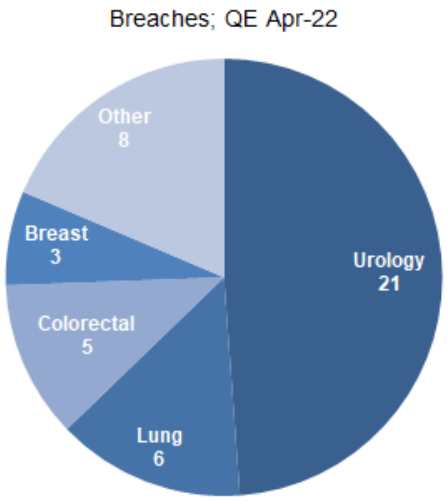
New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Cancer 62-Day Referral to Treatment

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days

Local Performance





National Benchmarking

Month	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	79.4%	82.1%	92.5%	91.3%	82.9%	83.3%	85.0%	75.4%	71.2%	83.6%	78.6%	84.9%
Scotland	83.0%	83.6%	82.8%	83.5%	83.1%	78.8%	78.1%	78.3%	76.3%	77.4%	75.5%	77.0%

IMPROVEMENT ACTIONS

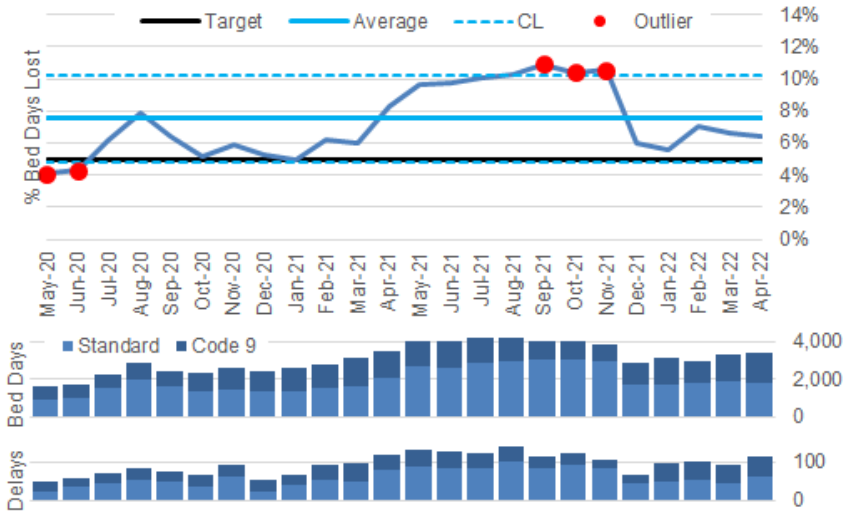
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-23**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways, initially prostate, and introduction of the optimal lung cancer pathway will also be prioritised.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-23**
A national review of the prostate pathway will be undertaken as part of the Recovery Plan. Small tests of change have been made within the pathway and further improvement measures continue.	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan	**By Jun-22**
The National Cancer Recovery Plan was published in December 2020. A Strategic & Governance Cancer Group has been established with a Cancer Framework Core Group to develop and take forward the NHS Fife Cancer Framework and annual delivery plan for cancer services in Fife. Engagement is completed and first draft edits have been made. The delivery plan in currently under review and will be tabled at the next Cancer Governance and Strategy Group.	
22.1 Effective Cancer Management Review	**Complete May-22**
The Scottish Government Effective Cancer Management Framework review to improve cancer waiting times performance is underway. The recommendations from the review will be addressed as part of the improvement process. The Scottish Government will be visiting NHS Fife to introduce the reviewed Framework. An action plan has been completed and forwarded to Scottish Government. A further action to implement the effective cancer management framework will be determined for 2022-23 through the annual delivery plan.	

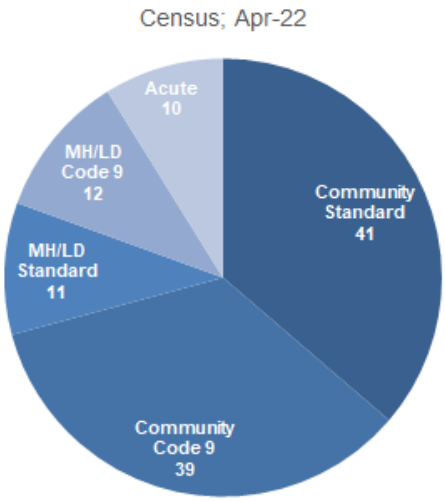
New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Delayed Discharges (Bed Days Lost)

We will limit the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

Local Performance





National Benchmarking

Quarter Ending		2019/20		2020/21				2021/22		
		Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	% Bed Days Lost - Std	7.2%	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%	10.4%	9.0%
	% Bed Days Lost - All	10.4%	12.4%	8.6%	10.1%	9.6%	10.9%	14.4%	14.8%	12.4%
Scotland	% Bed Days Lost - Std	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%	6.8%	7.2%
	% Bed Days Lost - All	8.8%	9.3%	5.9%	7.1%	7.3%	7.3%	7.4%	9.4%	9.7%

IMPROVEMENT ACTIONS

21.1 Progress HomeFirst model / Develop a 'Home First' Strategy	**By Dec-22**
The Oversight "Home First" group continue to meet on a regular basis, and Project Management Office (PMO) support is in place. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Monthly meetings take place, and this action will continue for the remainder of 2022.	
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**Complete May-22**
This test of change has now ended. We intend to review lessons learned and consider a second test of change in the community.	

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Finance

NHS Boards are required to work within the revenue and capital resource limits set by the Scottish Government Health Care Directorates (SGHSCD)

1. Executive Summary

1.1 At the end of May the board's reported financial position is an overspend of £6.453m on Health Retained. This overspend comprises: £2.061m core overspend (of which £0.855m relates to Acute Set Aside overspend); £1.735m opening financial gap; and as yet unfunded Covid-19 costs of £2.657m (including £1.078m Public Health Test and Protect costs).

The Health Delegated position reflects a core underspend of £1.043m.

Revenue Financial Position as at 31 May 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
NHS Services (incl Set Aside)				
Clinical Services				
Acute Services Division	238,149	40,588	41,879	-1,291
IJB Non-Delegated	9,426	1,563	1,541	22
Non-Fife & Other Healthcare Providers	94,380	15,719	16,268	-549
Non Clinical Services				
Estates & Facilities	78,712	13,053	13,053	0
Board Admin & Other Services	74,277	12,337	12,415	-78
Other				
Financial Flexibility & Allocations	32,784	189	0	189
Income	-29,556	-4,935	-4,914	-21
Grip and Control	-2,000	-333	0	-333
Sub-total Core position	**496,172**	**78,181**	**80,242**	**-2,061**
Financial Gap	-10,408	-1,735		-1,735
HB retained Covid 19	**1,164**	**1,164**	**3,821**	**-2,657**
SUB TOTAL	**486,928**	**77,610**	**84,063**	**-6,453**
Health & Social Care Partnership				
Fife H & SCP	374,525	61,460	60,417	1,043
Health delegated Covid 19	1,672	1,672	1,672	0
SUB TOTAL	**376,197**	**63,132**	**62,089**	**1,043**
TOTAL	**863,125**	**140,742**	**146,152**	**-5,410**

1.2 NHS Fife Board approved the financial plan for 2022/23 on 29 March 2022. The Strategic Planning and Resource Allocation (SPRA) process which took place in Autumn/Winter 2021, endorsed by the Executive Director Group and the NHS Fife Board, captured key cost pressures for the board and in the main identified the significant level of existing cost pressure of £19.9m within Acute Services which has been recognised in the financial plan. Our financial plan (at Appendix 1) has a cost improvement target for 2022/23 of £24.1m (circa 5% of Health retained baseline budget). Cost improvement plans of £11.7m (at Appendix 2) have been agreed with directorates and their respective Senior Responsible Officers. In addition, a £2m capital to revenue transfer to provide non-recurring support in the main for locally and nationally agreed cost pressures has also been approved. We have highlighted to Scottish Government (SG) our current resulting financial gap of £10.4m through the financial planning process and have identified a "pipeline" of emerging potential plans which will begin to contribute to the remaining gap over the medium term. The financial gap arises in the main from the recognised cost pressures in Acute Services of £19.9m.

1.3 The Board's Financial Plan for 2022/23 was developed on the assumption of receipt of full funding for the ongoing additional costs of managing the Covid 19 pandemic in line with Scottish Government (SG) advice at the time of writing the plan. However, the financial plan also referred to several specific and inherent risks within the plan, including the availability of Covid 19 funding to match our net additional costs. At the end of February 2022, SG provided additional Covid 19 funding to NHS Boards and Integration Authorities to meet Covid 19 costs in year and to support the ongoing impact of the pandemic. Any funding remaining at year end 2021/22 was carried forward in an earmarked reserve for Covid 19 purposes by the Integration authorities. Use of this funding continues to be discussed by the IJB Chief Finance Officer and the NHS Director of Finance targeting the additional Covid 19 costs in the Integration Board as well as the NHS Board in 2022/23. A national Covid Cost Improvement programme to support delivery of efficient cost reduction measures has been established to transition towards Covid related costs being accommodated in the Health and Social care Directorate funding envelope

1.4 At present no formal allocation letters have been issued by SG. A formal Quarter 1 review will take place which will look at the initial AOP submitted in March and also re-introduce the 3 year planning cycle. Appendix 3 shows our recurring baseline as per the Scottish Budget with details of all anticipated allocations for both core and non-core allocations.

1.5 With regard to Covid-19 funding, the SG confirmed an allocation of £7.5m for 2022/23. This funding has not yet been received nor has it been recognised in our month 2 reporting position. In addition we await funding confirmation on Public Health measures including test & protect (£1.078m unfunded spend to month 2). The Health Delegated covid spend including Covid vaccine costs is expected to be met from the Covid-19 earmarked reserve.

1.6 The overall anticipated capital budget for 2022/23 is £24.837m. The capital position for the period to May records spend of £1.595m. Therefore, 6.42% of the anticipated total capital allocation has been spent to month 2. The full capital programme is expected to deliver in full with significant activity in the final month of the year working towards a balanced capital position.

2. Health Board Retained Services

Clinical Services financial performance as at 31 May 2022 excluding Covid-19 costs

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Acute Services Division (HB Retained)	196,727	33,605	34,041	-436
Acute Services Division (Acute Set Aside)	41,422	6,983	7,838	-855
IJB Non Delegated	9,426	1,563	1,541	22
Non-Fife & Other Healthcare Providers	94,380	15,719	16,268	-549
Income	-29,556	-4,935	-4,914	-21
SUB TOTAL	**312,399**	**52,935**	**54,774**	**-1,839**

2.1 The Acute Services Division reports a core **overspend of £1.291m.** Acute Services continue to experience challenging capacity pressures at the front door and downstream wards in addition to delayed discharges. Measures are underway to ease the pressures and discussions are taking place around reliance on supplementary staffing within Acute. Key factors driving the non-pay overspend position to May of £0.395m relate to, continued medicines growth, diabetic pumps and the ongoing outsourcing of radiology reporting. Pay overspend of £0.273m is due to the delay in reducing supplementary staffing costs, which is one of the agreed cost improvement areas for Acute. Additionally, we await the outcome of a Labs and Radiology bid submitted to Scottish Government requesting funding of £1.7m. Expenditure has been incurred against this scheme and currently contributes to the overspend position. Additionally, the Acute directorate are incurring expenditure for Waiting List Initiatives but the level of available funding has not been increased to reflect the pay growth on substantive contracts and is also contributing to a level of the overspend. Discussions are ongoing with SG in relation to this issue. The remainder of the reported overspend to May relates to unachieved savings of £0.124m, with an expectation the pipeline schemes will cover any in year slippage.

Progress is underway with schemes funded by Scottish Government focusing on Interface Care and Discharge Without Delay and posts continue to be appointed to on a non-recurring basis to support the transition of service delivery to more streamlined patient pathways.

Included in the core ASD position is an overspend on Set aside services of £0.855m which is being funded on a non-recurring basis by the board. The full year cost pressure on set aside budgets is circa £6m and is included in the board's financial plan gap of £10.4m.

2.2 The IJB Non-Delegated budget reports an **underspend of £0.022m.** This is within Acute Services within the North East Fife Hospitals.

2.3 The budget for healthcare services provided out-with NHS Fife is **overspent by £0.549m** which reflects cost pressures within the SLAs with Tayside, Lothian, Forth Valley and private healthcare providers and includes a cost improvement target. Work is underway to develop a cost improvement plan to mitigate costs wherever possible and in the first instance a detailed review of private sector healthcare providers for mental health services is underway. Further detail is contained in Appendix 4.

2.4 Corporate Functions and Other Financial performance at 31 May 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Non Clinical Services				
Estates & Facilities	78,712	13,053	13,053	0
Board Admin & Other Services	74,277	12,337	12,415	-78
Other				
Financial Flexibility & Allocations	32,784	189	0	189
SUB TOTAL	**185,773**	**25,579**	**25,468**	**111**

2.5 The Estates and Facilities budgets report a **break-even position.** This comprises an underspend in pay of £0.158m which is continuing the trend of last year across several departments including estates services, catering, and portering. Non-pay costs are over spent by £0.158m with energy and clinical waste the main drivers. Also, this month there has been roof repairs of £0.051m at QMH and Leven Health Centre.

2.6 Within the Board's corporate services there is **an overspend of £0.078m**. Driven mainly by allocation of the in-year Cost Improvement Target and work continues to regain traction on this.

Financial Flexibility

2.7 Financial flexibility at the end of the May reflects allocation and uplift assumptions held corporately including supplies, medical supplies and drugs uplifts. The release of this flexibility and allocations will take place as the year unfolds and as the financial impact of national policies crystallise. A summary of funding held in **financial flexibility** and the release of **£0.189m** to month 2 is shown at Appendix 5.

Financial Gap

2.8 The **financial plan gap** at month 2 reflects the proportionate share of the planned £10.4m deficit **(£1.735m** to month 2) which will be addressed as part of our medium-term (3 year) financial planning.

Approved Cost Improvement Plans

2.9 During the first quarter of the financial year significant activity has been taken forward led by each Senior Responsible Officer (SRO), to develop and implement the approved cost improvement plans. A summary by SRO of the status of approved plans is included in the table below.

Overall Summary

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non -Rec £'000	Made up of:	Current RAG / Narrative against delivery of £11.7M within 2022/23 Financial Year
Acute Services Directorate	**4450**	**4345**	1000	**14 CIP schemes – all in Delivery**	**£105k Overall Shortfall –** pipeline projects being reviewed to mitigate
Pharmacy & Medicines Directorate	**920**	**638**	**262**	**20 CIP schemes** – 11 delivering recurring savings, 9 non-recurring making up in-year shortfall before all recurring savings kick in	**Confidence in delivery** – additional substantial schemes in Pipeline
Property & Infrastructure	**1330**	**1330**		**6 CIP schemes – all in Delivery**	**Confidence in delivery** – weighted towards last Quarter
Vacancy Factor	**3000**	**3000**		**Split across 10 directorates / areas**	**TBC**
Financial Grip & Control	**2000**	**2000**		**TBC**	CIP in Development
Total	**11700**	**11595**	**262**	**OVERALL RAG**	**Projected to deliver on Target**

To the end of May, actual cost improvement delivered total £0.747m as per the table below against a plan of £1.638. The majority of the slippage in plans is in relation to the vacancy factor which was only approved and allocated to directorates for their May financial performance. The slippage within Acute services is in relation to vacancy factor also and it is anticipated this will be picked up in later months as actions are taken by the directorates.

Approved Cost Improvement Plans - Position at 31 May 2022

Budget Area	Current Year Target £'000	Year to Date Target £'000	Year to Date Achieved £'000	Year to Date Variance £'000
Acute	5,752	288	164	-124
Estates & Facilities	1,250	500	503	3
Corporate	4,698	850	80	-770
Total	**11,700**	**1,638**	**747**	**-891**

3. Health Board Covid-19 spend

3.1 With regard to Covid-19 funding, a letter was received from SG on 1 June advising of a £7.5m Covid-19 for 2022-23. This funding has not yet been received or recognised in our month 2 reporting position. In addition we await funding confirmation on Public Health measures including test & protect (£1.078m unfunded spend to month 2).

HB & Acute set aside Covid-19 spend	Year to Date Budget £'000	YTD Spend HB Retained £'000	YTD Spend Set Aside £'000	YTD Spend Total £'000	YTD Variance £'000
Acute	1,164	1,079	1,164	2,243	-1,079
Estate & Facilities	-	41	161	202	-202
Corporate	-	276	22	298	-298
Public Health	-			1,078	-1,078
Total	**1,164**	**1,396**	**1,347**	**3,821**	**-2,657**

3.2 An additional layer of transparency around Covid-19 expenditure has been added for this financial year to encompass the breakdown of expenditure between HB Retained costs and those relating to Acute Set Aside.

3.3 Acute Services continue to incur Covid expenditure for services which have not yet scaled back and general delays in transfer of care due to the Covid impact in Community settings. Point of Care testing continues and NMAB clinics provide access to medication for Covid positive individuals in a bid to prevent hospital admissions. Staff absences for covid reasons also continue to drive sickness absence costs. Discussions with services are ongoing to determine an exit strategy for Covid expenditure and to gain an understanding of what will remain as business as usual in the future.

3.4 Corporate budgets continue to incur Covid-19 costs. Detailed work continues with services to secure exit planning and absorption of the Covid-19 costs into core costs.

3.5 Public Health colleagues have established a short life working group to work through the staffing implications of the ending of Contact Tracing, Asymptomatic Testing and Fixed Term Public Health roles. The current level of spend will fall over the coming months. A level of symptomatic testing will continue which is currently being modelled nationally.

3.6 It is anticipated funding for 2022/23 Covid-19 costs in respect of Acute set aside Covid-19 spend will be met from the Covid allocations provided in 2021/22 to the Integration Joint Board.

4. Health & Social Care Partnership

4.1 Health services in scope for the Health and Social Care Partnership report a core **underspend of £1.043m.**

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Health & Social Care Partnership				
Fife H & SCP	376,198	63,133	62,090	1,043
SUB TOTAL	**376,198**	**63,133**	**62,090**	**1,043**

The Health and Social Care Partnership budget detailed above are Health budgets designated as in scope for HSCP integration, excluding services defined as Set Aside. The financial pressure related to 'Set Aside' services is currently held within the NHS Fife financial position. These services are currently captured within the Clinical Services areas of this report (Acute set aside £0.855m overspend to month 2 per 1.1 above). Anticipated funding from the IJB earmarked reserve is shown at Appendix 7.

4.2 HSCP Covid-19 spend

The Health Delegated covid spend of £1.672m to month 2, including Covid vaccine costs, will be met from the Covid-19 earmarked reserve.

Health Delegated Covid-19 spend Budget Area	Budget £'000	YTD Spend £'000	YTD Variance £'000
Community Care Services	467	467	0
Complex And Critical Services	48	48	0
Primary Care + Prevention Ser	81	81	0
Professional/business Enabling	23	23	0
Covid-19 Vaccination Costs	1,053	1,053	0
Total	**1,672**	**1,672**	**0**

5. Risks

5.1 There is a risk around the Health Board retained Covid-19 costs and funding levels which encompass Acute, Acute set-aside and Corporate function costs.

5.2 There is a significant risk around Public Health test and protect and track and trace funding where we await confirmation of funding arrangements.

5.3 There is a lack of certainty over future funding allocations, for example: Redesign of Urgent Care and International Recruitment.

5.4 There are a number of ongoing inflationary price increases e.g. energy price increases, the cost of food and building materials. Whilst some assumptions have been made in the financial planning process, detailed work remains ongoing to capture and forecast the potential impact for NHS Fife.

6. Capital

6.1 The overall anticipated capital budget for 2022/23 is £24.837m. The capital position for the period to May records spend of £1.595m. Therefore, 6.42% of the anticipated total capital allocation has been spent to month 2.

6.2 The capital plan for 2022/23 is pending approval by the FP&R Committee in July and will subsequently be tabled at the NHS Fife Board. NHS Fife has assumed a programme of £24.837m detailed in the table below.

Capital Plan	£'000
Initial Capital Allocation	7,764
Elective Orthopaedic Centre	13,389
Kincardine Health Centre	856
Lochgelly Health Centre	1,228
QMH Theatres PH2	1,500
Mental Health	100
Total	**24,837**

The Kincardine & Lochgelly Health Centres are still subject to approval at OBC stage. Confirmation on Health Centre plans approval status is anticipated following SCIG on 29 June 2022.

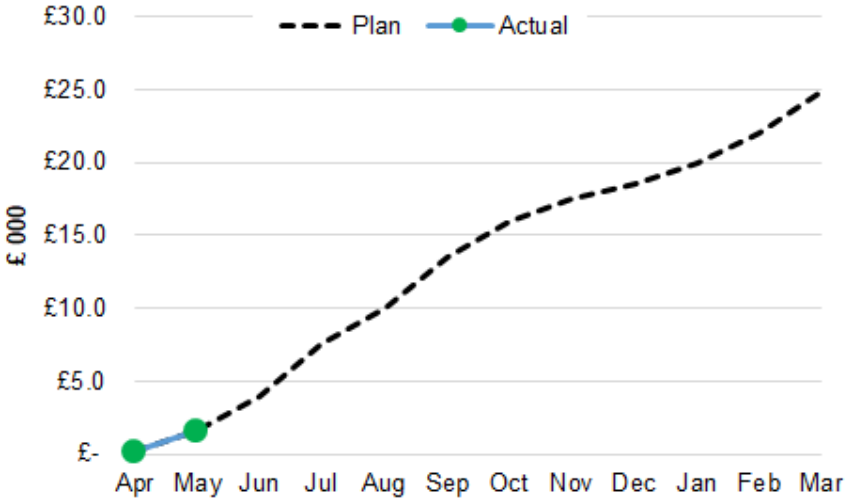
6.3 Capital Receipts

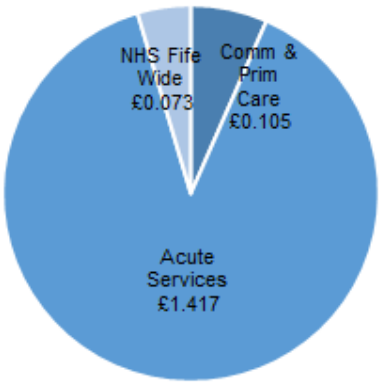
Work continues into the new financial year on asset sales re disposals:

- Lynebank Hospital Land (Plot 1) (North) – discussions are ongoing as to whether to remarket, there are also discussions ongoing around the potential possibility of HFS constructing a new sterilising unit for East Scotland on the site.
- Skeith Land – an offer has been accepted subject to conditions for planning and access - however the GP's have now put in an objection to the planning department. The Developers have provided other plans in order to move forward, however, the GP's are still objecting.

6.4 Expenditure / Major Scheme Progress

The summary expenditure position across all projects is set out in the dashboard summary above. The expenditure to date amounts to £1.595m, this equates to 6.42% of the total anticipated capital allocation, as illustrated in the spend profile graph above.





The main areas of spend to date include:

Statutory Compliance	£0.479m
Equipment	£0.088m
Digital	£0.073m
Elective Orthopaedic Centre	£0.856m
Health Centres	£0.099m

6.5 The full capital programme is expected to deliver in full with significant activity in the final month of the year working towards a balanced capital position. Further detail on capital expenditure are detailed in Appendices 8 and 9.

7 Recommendation

7.1 EDG is asked to consider the detail of this report and specifically:

- **Note** the reported core overspend £6.453m
- **Note** the Health delegated core underspend position £1.043m
- **Note** the capital expenditure spend of £1.595m .

Appendix 1

NHS Fife 2022/23 Financial Plan	Total £'000	IJB £'000	HB retained £'000	
Expenditure FY budget roll forward	878,069	408,956	469,113	**
Allocation Uplifts 22/23 per SG announcement	25,492	9,171	16,321	
Available budget	**903,561**	**418,127**	**485,434**	
FP Uplift Assumptions 22/23				
21/22 ASD pressures	19,900	*	19,900	
22/23 pressure	7,000	*	7,000	
Financial Flexibility	-2,800	*	-2,800	
Budget requirement	**927,661**	**418,127**	**509,534**	
Initial gap	**-24,100**	**0**	**-24,100**	
Approved CIPs	11,700	*	11,700	
Cap to rev transfer	2,000	*	2,000	
Opening budget 22/23	**917,261**	**418,127**	**499,134**	
Agreed remaining gap for 22/23	**-10,400**	**0**	**-10,400**	

*to be considered through IJB financial planning process

** includes **Acute set aside** of **£38.899m**

Appendix 2: Approved Cost Improvement Plans

Confirmed Cost Improvement Plans 2022/23				
SRO	**Area**	**Plan**	**£'000**	**£'000**
		Procurement:		
Acute	PCD	Instruments & Sundries & CSSD	1,000	
Acute	PCD	Investment in Theatres Procurement/Cost reduction	500	
		Service Commissioning:		
Acute	PCD	Repatriation of Radical Prostatectomy	205	
Acute	WCCS	Travel, Printing	60	
Acute	WCCS	Managed Service Contract for Labs	425	
		Service Redesign:		
Acute	WCCS	Skill mix review	50	
		Pharmacy:		
Acute	ECD	Pirfenidone and Nintedanib Homecare	40	
Acute	ECD	Patent Expiry/ Homecare	160	
Acute	WCCS	Community Paediatric Drugs	20	
		Supplementary Staffing:		
Acute	Acute	Reduction in non core staffing	2,000	
Acute	WCCS	Vacancy release	210	4,670
		Pharmacy & Medicines Directorate		
Pharmacy		Medicines Efficiency, PAS Rebates, Contract Changes	700	700
		Property & Infrastructure		
P&I		Major Contract Review	250	
P&I		Property Maintenance Minor Works Team	100	
P&I		Energy Savings - NDEE Project	150	
P&I		Rates Review	500	
P&I		Roster Review	250	
P&I		Terminate Lease for Evans Business Park	80	1,330
		Vacancy Factor		
All	All	Vacancy Factor (less than 1% of total pays)	3,000	3,000
		Financial Grip & Control		
Finance	All	Financial Control across all areas of spend and financial flexibility/Accelerate from Pipeline Projects where possible	2,000	2,000
		Total	**11,700**	**11,700**

Appendix 3: Revenue Resource Limit

		Baseline Recurring	Earmarked Recurring	Non-Recurring	Total
		£'000	£'000	£'000	£'000
	Initial Baseline Allocation	723,323			723,323
	Total Core RRL Allocations	**723,323**	**0**	**0**	**723,323**
Anticipated	Primary Medical Services		59,263		59,263
Anticipated	Outcomes Framework		4,520		4,520
Anticipated	Mental Health Bundle		1,363		1,363
Anticipated	Salaried Dental		2,090		2,090
Anticipated	Distinction Awards		139		139
Anticipated	Research & development		822		822
Anticipated	Community Pharmacy Champions		20		20
Anticipated	NSS Discovery		-40		-40
Anticipated	Pharmacy Global Sum Calculation		-204		-204
Anticipated	NDC Contribution		-843		-843
Anticipated	Community Pharmacy Pre-Reg Training		-165		-165
Anticipated	Patient Advice & Support Service		-39		-39
Anticipated	**FNP**		1,425		1,425
Anticipated	**New Medicine Fund**		6,683		6,683
Anticipated	**Golden Jubilee SLA**		-25		-25
Anticipated	**PCIF**		10,037		10,037
Anticipated	**Action 15 Mental Health strategy**		2,121		2,121
Anticipated	ADP:seek & treat		1,159		1,159
Anticipated	Veterans First Point Transisition Funding		116		116
Anticipated	Tariff reduction to global sum		-4,245		-4,245
Anticipated	District Nurses		333		333
Anticipated	ADP		920		920
Anticipated	School Nurse		276		276
Anticipated	Perinatal and Infant Mental Health		663		663
Anticipated	Primary care development funding		30		30
Anticipated	CAMHS		704		704
Anticipated	National Cancer Recovery Plan SPOC		64		64
Anticipated	National SACT Pharmacy		8		8
Anticipated	Mental Health Funding Pharmacy recruitment		64		64
Anticipated	Mental health & Wellbeing primary care services		105		105
Anticipated	Waiting list			6,700	6,700
Anticipated	Uplift 22/23	25,492			25,492
Anticipated	Capital to Revenue			2,000	2,000
Anticipated	Covid 19 Retained			7,500	7,500
Anticipated	Young Peoples fund		10		10
Anticipated	Band 2-4		895		895
Anticipated	TAC		1,000		1,000
Anticipated	ICU		799		799
Anticipated	Additional Waiting List			1,189	1,189
Anticipated	Radiology			948	948
Anticipated	NSD etc		-4,531		-4,531
Total Anticipated		**25,492**	**85,537**	**18,337**	**129,366**
		748,815	**85,537**	**18,337**	**852,689**
Anticipated	IFRS			9,301	**9,301**
Anticipated	Donated Asset Depreciation			135	**135**
Anticipated	Impairment			500	**500**
Anticipated	AME Provisions			500	**500**
Anticipated					**0**
Anticipated					**0**
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**10,436**	**10,436**
	Grand Total	**748,815**	**85,537**	**28,773**	**863,125**

Appendix 4: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	101	17	16	1
Borders	47	8	9	-1
Dumfries & Galloway	26	4	10	-6
Forth Valley	3,311	552	612	-60
Grampian	374	62	47	15
Greater Glasgow & Clyde	1,724	287	279	8
Highland	141	23	34	-11
Lanarkshire	120	20	36	-16
Lothian	32,822	5,470	5,566	-96
Scottish Ambulance Service	105	18	17	1
Tayside	41,258	6,878	7,164	-286
Cost Improvement target	-1,817	-303		-303
	78,212	**13,036**	**13,790**	**-754**
UNPACS				
Health Boards	14,182	2,363	2,096	267
Private Sector	1,181	197	260	-63
	15,363	**2,560**	**2,356**	**204**
OATS	740	123	122	1
Grants	65			0
Total	**94,380**	**15,719**	**16,268**	**-549**

Appendix 5: Financial Flexibility

		Flexibility Released to May-22
	£'000	£'000
Drugs :NMF	1,359	
Junior Doctor Travel	47	
Consultant increments	441	
Discretionary Points	232	
AME impairments	500	
AME Provisions	634	
Prior Years Approved Developments, National Initiatives	2,509	189
Health Retained 22-23 Uplifts	8,514	
Cost pressures 22-23	4,179	
Allocations to be distributed	14,369	
Total	**32,784**	**189**

Appendix 6: Detailed Cost Improvement Plans

Area	Plan	Current Year Target £'000	Year to Date Target £'000	Year to Date Achieved £'000	Year to Date Variance £'000
PCD	Instruments & Sundries	1,000	70	70	0
PCD	Investment in Theatres Procurement / Cost Reduction	500	0	0	0
PCD	Repatriation of Radical Prostatectomy	205	0	0	0
WCCS	Travel & Printing	60	12	12	0
WCCS	Managed Service Contract for Labs	425	71	46	(25)
WCCS	Skill Mix Review	50	7	6	(0)
ECD	Pirfenidone / Nintedanib	40	7	7	0
ECD	Patent Expiry / Homecare	160	0	0	0
WCCS	Community Paediatric Drugs	20	3	3	0
Acute	Reduction in Non Core Staffing	2,000	0	0	0
WCCS	Vacancy Release	210	33	0	(33)
Pharmacy	Medicines Efficiency, PAS Rebates, Contract Changes	700	21	19	(2)
P&I	Major Contract Review	250	0	0	0
P&I	Property Maintenance Minor Works Team	100	0	0	0
P&I	Energy Savings - NDEE Project	150	0	0	0
P&I	Rates Review	500	500	503	3
P&I	Roster Review	250	0	0	0
P&I	Terminate Lease for Evans Business Park	80	80	80	0
All	Vacancy Factor	3,000	500	0	(500)
All	Financial Grip & Control	2,000	333	0	0 (333)
	Total	**11,700**	**1,638**	**747**	**(891)**

Appendix 7: Anticipated Funding from Health Delegated Earmarked Reserve

	2021/22 Earmarked Reserve **£'000**	Anticipated at May-22 **£'000**
Covid-19 earmarked reserve - SG letter February 2022	35,478	1,784
Vaccine	2,472	1,053
ADP (from Core)	1,700	0
Primary Care Improvement Fund	6,585	0
Care homes	817	0
Urgent Care Redesign	950	139
Action 15	1,791	0
RT Funding	1,500	0
FSL	0	0
District Nurses	213	0
Fluenz	18	0
Mental Health Recovery & Renewal	3,932	100
Workforce Wellbeing	244	0
Budival	213	0
Child Healthy Weight	23	0
Acceleration of 22/23 MDT recruitment	300	0
Multi Disciplinary Teams	1,384	0
GP Premises	430	0
Afghan Refugees	47	0
Dental Ventilation	669	0
Interface care	170	0
Core general reserve	4,125	0
Core underspend	3,409	0
TOTAL	**66,470**	**3,076**

Appendix 8 : Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2022/23 £'000
COMMUNITY & PRIMARY CARE			
Clinical Prioritisation	53	0	53
Statutory Compliance	346	6	346
Capital Equipment	14	0	14
Condemned Equipment	0	0	0
Total Community & Primary Care	413	6	413
ACUTE SERVICES DIVISION			
Statutory Compliance	1,890	473	1,890
Capital Equipment	1,130	88	1,130
Clinical Prioritisation	0	0	0
Condemned Equipment	13	0	13
QMH Theatre	734	0	734
Total Acute Services Division	3,767	561	3,767
NHS FIFE WIDE SCHEMES			
Equipment Balance	263	0	263
Information Technology	877	73	877
Clinical Prioritisation	197	0	197
Statutory Compliance	160	0	160
Condemned Equipment	87	0	87
Fire Safety	0	0	0
Scheme Development	0	0	0
Vehicles	0	0	0
Capital to Revenue Transfer	2,000	0	2,000
Total NHS Fife Wide Schemes	3,584	73	3,584
TOTAL CAPITAL ALLOCATION FOR 2022/23	**7,764**	**641**	**7,764**

ANTICIPATED ALLOCATIONS 2022/23			
QMH Theatres PH2	1,500	0	1,500
Kincardine Health Centre	856	50	856
Lochgelly Health Centre	1,228	49	1,228
Mental Health Review	100	0	100
Elective Orthopaedic Centre	13,389	856	13,389
Anticipated Allocations for 2022/23	**17,073**	**955**	**17,073**

Total Anticipated Allocation for 2022/23	**24,837**	**1,595**	**24,837**

Appendix 9: Capital Plan - Changes to Planned Expenditure

Capital Expenditure Proposals 2022/23 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to April £'000	May Adjustment £'000	Total May £'000
Community & Primary Care				
Capital Equipment	0	0	20	20
Condemned Equipment	0	0	0	0
Clinical Prioritisation	0	0	105	105
Statutory Compliance	0	341	5	346
Total Community & Primary Care	**0**	**341**	**130**	**470**
Acute Services Division				
Capital Equipment	0	144	986	1,130
Condemned Equipment	0	0	13	13
Clinical Prioritisation	0	0	30	30
Statutory Compliance	0	1,891	-1	1,890
QMH Theatre	734	0	0	734
	734	**2,035**	**1,028**	**3,798**
Fife Wide				
Backlog Maintenance / Statutory Compliance	2,396	-2,232	-4	160
Fife Wide Equipment	1,407	-144	-1,006	257
Digital & Information	877	0	0	877
Clinical Prioritisation	250	0	-135	115
Condemned Equipment	100	0	-13	87
Capital to Revenue Transfer	2,000	0	0	2,000
Fife Wide Fire Safety	0	0	0	0
Fife Wide Vehicles	0	0	0	0
Total Fife Wide	**7,030**	**-2,376**	**-1,158**	**3,496**
Total Capital Resource 2022/23	**7,764**	**0**	**0**	**7,764**

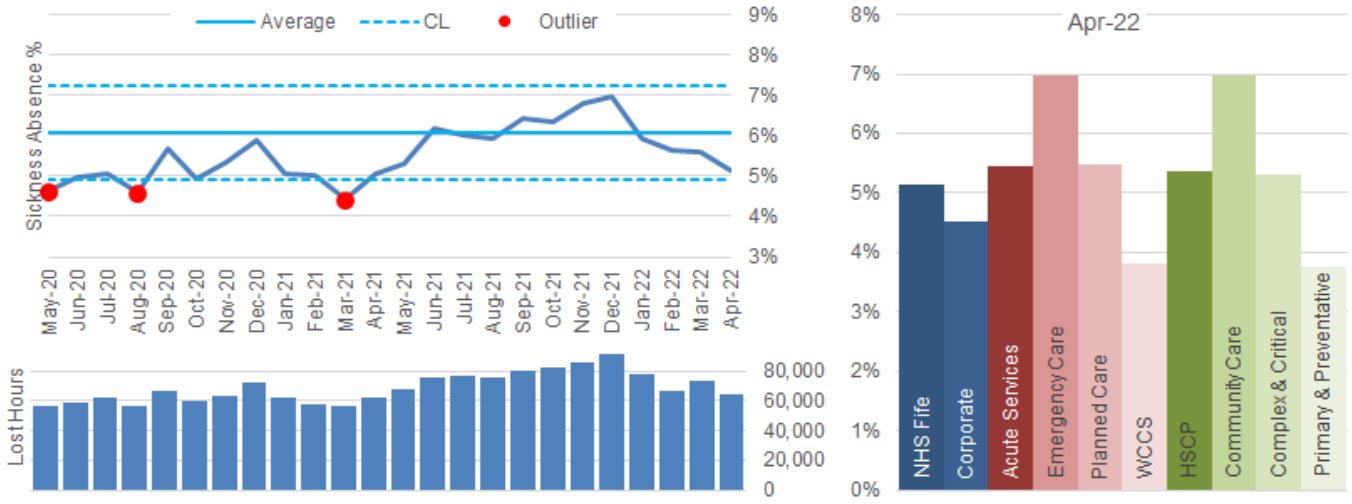
ANTICIPATED ALLOCATIONS 2022/23				
QMH Theatres PH2	1,500	0	0	1,500
Kincardine Health Centre	856	0	0	856
Lochgelly Health Centre	1,228	0	0	1,228
Mental Health Review	100	0	0	100
Elective Orthopaedic Centre	13,389	0	0	13,389
Anticipated Allocations for 2022/23	**17,073**	**0**	**0**	**17,073**

Total Planned Expenditure for 2022/23	**24,837**	**0**	**0**	**24,837**

Sickness Absence

*To achieve a sickness absence rate of 4% or less (Improvement Target for 2022/23 = **TBD**%)*

Local Performance



National Benchmarking

Month	2021/22											2022/23
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
NHS Fife	5.31%	6.17%	6.03%	5.95%	6.42%	6.34%	6.79%	6.98%	5.93%	5.63%	5.59%	5.14%
Scotland	5.04%	5.52%	5.62%	5.76%	6.12%	6.30%	6.37%	6.23%	5.37%	4.96%	5.47%	5.10%

IMPROVEMENT ACTIONS

22.1 Work towards improvement in long term sickness absence relating to mental health, using Occupational Health and other support services and interventions	**By Mar-23**

Work is being progressed in a number of areas:

1. Continued early Occupational Health (OH) intervention for staff absent from work due to a mental health related reason, drawing on the specialist expertise from the OH Mental Health Nurse
2. Continued targeted managerial, Human Resources (HR) and wellbeing support for staff absent from work due to mental health related reasons
3. Introduction of Chartered Institute of Personnel and Development (CIPD) approved mental health checklist as a tool for mangers to use to support staff experiencing mental health issues.

22.2 Continue existing managerial actions in support of achieving the trajectory for the Board and the national standard of 4% for sickness absence	**By Mar-23**

Work is being progressed in a number of areas:

1. Provision of core HR, OH and staff wellbeing support to assist with achieving a reduction in sickness absence in line with the Annual Delivery Plan standard
2. Establishment of the Promoting Attendance Task Force chaired by the Chief Executive, to support the reduction in absence within NHS Fife; the first meeting of the Group is set for 9 June

   The aims of this Group include:

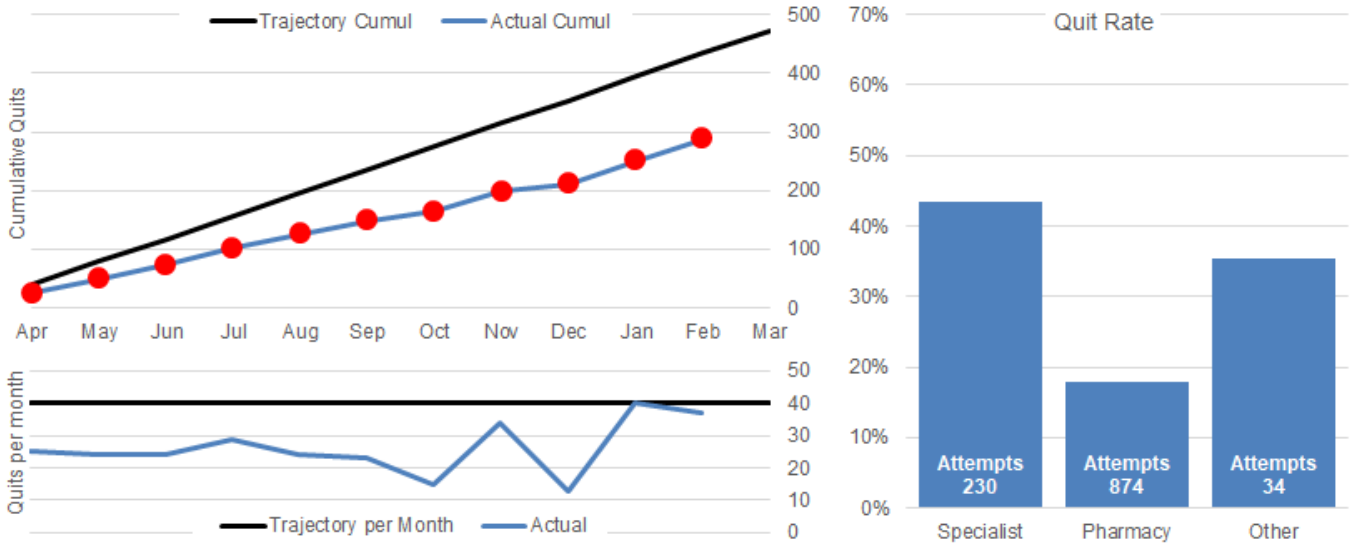
   - To facilitate NHS Fife to meet the requirements of attendance management in relation to Staff Governance Standards and NHS Scotland average of less than 4%
   - To drive forward improved attendance management in line with the target set, noting that from 1 April 2019 the aim was to work towards reducing sickness absence by 0.5% per annum over 3 years to 2022 with the target of achieving an overall NHS Scotland average of less than 4%
   - To enhance accountability of attendance management at Executive level
   - To support the implementation of locally agreed action plans
   - To refresh the current promoting attendance training offered within the Board and align it with the actions of the Attendance Task Force, alongside promotion of the Once for Scotland eLearning module to managers and staff.

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Smoking Cessation

In 2021/22, deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance (lag due to 12-week follow-up from quit date)



National Benchmarking

		2021/22											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	25	24	24	29	24	23	15	34	13	40	37	
	Actual Cumul	25	49	73	102	126	149	164	198	211	251	288	
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	62.5%	62.0%	61.9%	64.6%	64.0%	63.1%	59.4%	62.9%	59.6%	63.7%	66.4%	
Scotland	Achieved			92.4%			82.0%						

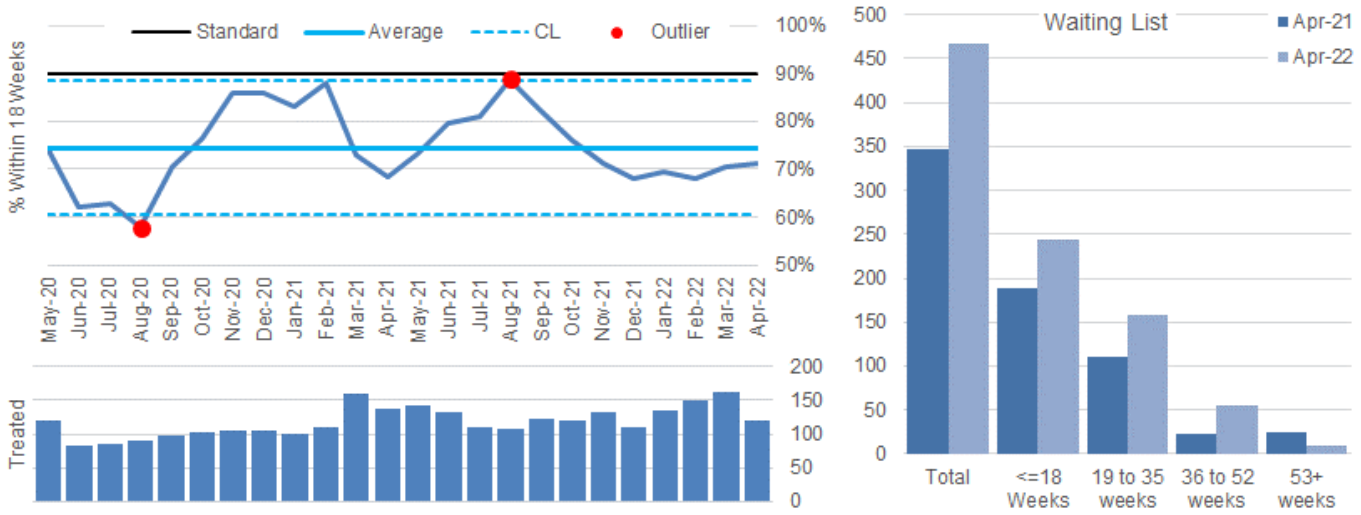
IMPROVEMENT ACTIONS

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance



National Benchmarking

Month	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	73.4%	79.5%	80.9%	88.8%	82.1%	76.0%	71.2%	68.2%	69.4%	68.0%	70.6%	71.1%
Scotland	71.8%	74.8%	75.9%	77.4%	82.1%	71.5%	70.5%	68.9%	73.9%	71.9%	73.8%	

IMPROVEMENT ACTIONS

21.3 Build CAMHS Urgent Response Team (CURT)	**By Oct-22**

The CURT model is in place. Responsiveness to A&E and Paediatric inpatient unit has been extended with same day assessments available if young people are considered fit for assessment. Presentations to Emergency department due to self harm/suicidal ideation remain high with a 180% increase through 2022. A second round of recruitment is underway following limited applications. This aims to increase the existing CURT staffing capacity from 2.8 wte to 6.6 wte to address the increasing referral trend for urgent presentations. A review of activity and effectiveness of the model is ongoing utilising improvement methodology.

22.1 Recruitment of Additional Workforce	**By Oct-22**

Recruitment is ongoing across multiple service areas to improve RTT, longest waits and CAMHS service provision. From the 12 staff identified to address immediate capacity issues, 9 have been appointed with remaining posts re-advertised at lower banding to improve uptake. All new staff have worked through an induction programme to ensure they are competent to take on caseloads and are incrementally increasing clinical activity towards full capacity. This is balanced against staff departures and retirements which have created 6 additional posts for recruitment.

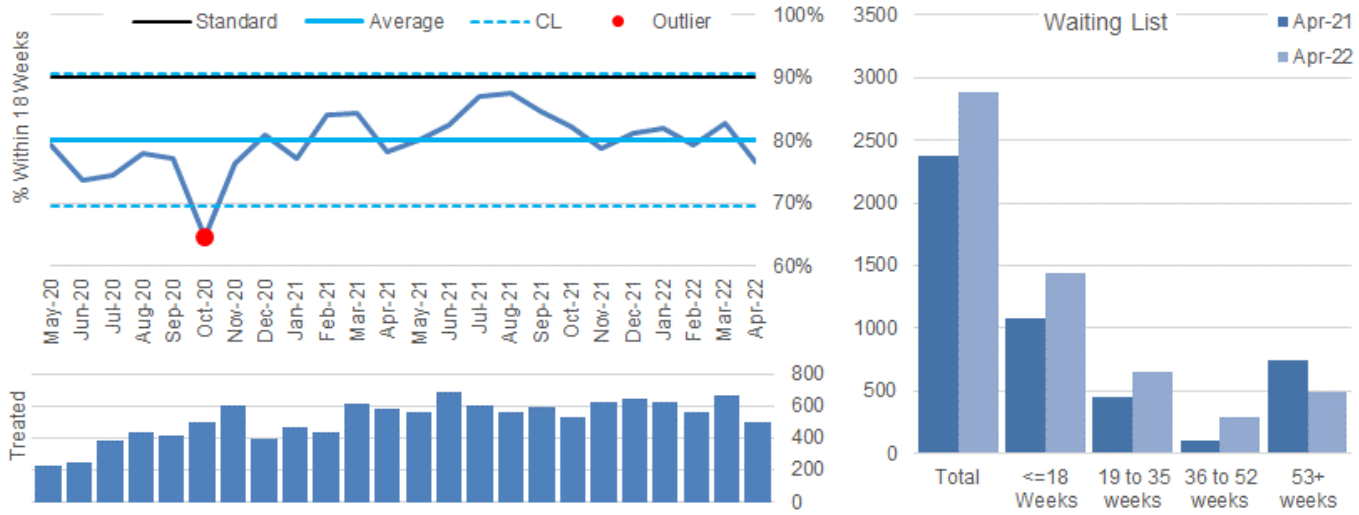
Phase 1 and Phase 2 recruitment as part of the SG Recovery & Renewal fund is underway. Currently Fife CAMHS has 16 wte posts either out to recruitment or in development with additional roles in admin (5.0 wte) and AHP (3.0 wte) at interview stage.

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance



National Benchmarking

Month	2021/22											2022/23
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
NHS Fife	80.0%	82.6%	86.9%	87.4%	84.5%	82.3%	78.8%	81.1%	81.8%	79.2%	82.7%	76.5%
Scotland	82.5%	84.3%	88.5%	87.0%	86.1%	85.5%	83.0%	85.1%	82.6%	82.0%	84.5%	

IMPROVEMENT ACTIONS

22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Aug-22**

There remain significant national issues with workforce availability for staff who can provide highly specialised PTs which would address our WL backlog. The service has been successful in recruiting other grades of staff to increase delivery of PTs for people with less complex problems and free some capacity amongst staff qualified to work with the more complex presentations. The NHS Education for Scotland national recruitment campaign was less successful than hoped but 1.8 WTE staff accepted offers and are going through pre-employment.

22.4 Waiting list management within General Medical Service in Clinical Health	**By Aug-22**

Staff are continuing to undertake a focused piece of work to clear the backlog on the assessment waiting list, and this is having a positive impact on the assessment waiting time. This has helped ensure that only those for whom psychological therapy is the best option remain on the waiting list. It will also inform next steps in development of clinical pathways. A key driver is the need to differentiate patients with functional neurological disorder (FND) from those with other needs in order to inform development of appropriate clinical pathways. Recruitment of a Specialist Clinical Psychologist to lead on development of the FND pathway is underway. In addition successful recruitment of a 0.8 WTE additional member of staff from the National Recruitment drive will increase capacity within General Medical.

New improvement actions for 2022/23 will be incorporated following approval of Annual Delivery Plan

NHS Fife

Meeting:	**Finance, Performance & Resources Committee**
Meeting date:	**12 July 2022**
Title:	**Integrated Performance & Quality Report Review Update**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Authors:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance
- Agreement

This report relates to:

- Integrated Performance and Quality Report

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Following the Active Governance workshop held on 2 November 2021, a review of the current Integrated Performance and Quality Report (IPQR) commenced by the establishment of a IPQR review group.

The first report presented to the Board on 29 March 2022 described the format of the IPQR and this paper focusses on which metrics are to be included within IPQR in 2022/23.

2.2 Background

The IPQR presents performance data and information on improvement activity across a range of key service areas. The report is considered to be a good example of effective integration of clinical service performance with workforce and financial information. It presents information on performance clearly and sets out improvement actions where performance is challenged. In line with good practice the report presentation is reviewed annually.

The first paper covered the new Public Health section, use of Statistical Process Control (SPC) Charts and pie charts and integration of improvement actions with RMP/SPRA process. This paper is to focus on which metrics are to be included within IPQR in 2022/23.

2.3 Assessment

The IPQR provides performance reporting to the Board and is a key element in effective governance through providing performance against key reporting. The purpose of bringing together performance and quality indicators in the IPQR is to provide the board a sense of performance across the whole health and care system.

The IPQR has historically contained the Scottish Government HEAT Standards but over time this has been extended to include quality and safety measures and relevant local metrics. The indicators included in the IPQR are high level system metrics that form part of an overall performance framework that include operational KPIs that are monitored through the performance review process at operational level.

Some discussion took place around performance metrics that are published on a yearly basis like drug related deaths and post diagnosis dementia support. These metrics are not included in the IPQR as they can not be monitored regularly throughout the year but are presented to the relevant committees after publication as a separate item.

The IPQR group have examined each section in detail and discussed the most important and relevant metrics to include as well as the connectivity between the metrics, risk and other quality measures and agreed these would be included in the new version of the IPQR.

This part of the SBAR will review each of the IPQR sections in turn and propose metrics for inclusion and removal.

Risk Management

Risk management is a critical to the effective running of the organisation and will be included in future IPQRs following this review. The risk section will report on the corporate risks for NHS Fife and will replace the current Board Assurance Framework.

Work is ongoing to sign off the corporate risks and once agreed through the governance structure, a risk section will be added to the IPQR from late summer 2022 with references to risks throughout the performance and improvement actions sections.

Review of Indicators

Clinical Governance Metrics

This is the first time the Clinical Governance section has been reviewed since it was included in the IPQR a few years ago.

Additional metric to be included will be in relation to open actions from Adverse Events which will be linked to the review of the adverse events policy. Meetings have already taken place around data availability with inclusion anticipated in 2022/23 Q2.

Metric relating to Caesarean Sections SSI is to be paused until further notice as mandatory SSI surveillance has been paused since the start of Covid-19 pandemic. Data received is not validated and does not follow NHS Fife methodology. Services are continuing to monitor cases and carry clinical reviews, if necessary.

Clinical Governance Metrics

Major & Extreme Adverse Events	Retain
Adverse Events Actions Open	*NEW*
HSMR	Retain
Inpatient Falls	Retain
Inpatient Falls with Harm	Retain
Pressure Ulcers	Retain
Caesarean Section SSI	Paused
SAB - HAI/HCAI	Retain
SAB - Community	Remove
C Diff - HAI/HCAI	Retain
C Diff - Community	Remove
ECB - HAI/HCAI	Retain
ECB - Community	Remove
Complaints (Stage 1 Closure Rate)	Retain
Complaints (Stage 2 Closure Rate)	Retain

Operational Performance

The group discussed the ongoing inclusion of 18 weeks RTT in the IPQR as this is not routinely performance managed as the Scottish Government focus on the delivery of the

three component areas of this target – outpatients, TTG (inpatients/daycase) and diagnostics. On referencing other NHS board performance reports, the 18 week RTT is no longer being reported.

It was agreed to replace Delayed Discharge counts from the scorecard with bed days lost metric to include code 9 reasons which includes Guardianship and ward closures. The existing performance metric focusses on standard delay codes however there are a high number of delays lost due to code 9 reasons.

The group discussed the revision of Information Governance metrics but it was felt that the proposed metrics were operational and not relevant for inclusion.

Source for Antenatal Access information will change from SMR02 to Antenatal Booking Collection (ABC). This was established in response to the pandemic to monitor the impact of COVID-19 on pregnant women. The data are collected from the clinical information systems, used by the midwives who 'book' the pregnant woman for maternity care. The data include all bookings, rather than only those resulting in a delivery, and are available within a few weeks of the booking appointment, rather than a month or more after delivery. Data from this new source is available from April 2019 onwards.

Operational Performance Metrics

IVF Treatment Waiting Times	Retain
4-Hour Emergency Access	Retain
Patient TTG	Retain
New Outpatients	Retain
Diagnostics	Retain
18 Weeks RTT	Remove
Cancer 31-Day DTT	Retain
Cancer 62-Day RTT	Retain
Detect Cancer Early	Retain
Freedom of Information Requests	Retain
ALL Delayed Discharge Bed Days Lost	*NEW*
Standard Delayed Discharge Bed Days Lost	Retain
Delayed Discharge (# Standard Delays)	Remove, figure in drilldown
Antenatal Access	Retain, new source

Public Health & Wellbeing

This is a new section in the IPQR since the creation of the Public Health and Wellbeing Committee in 2021. The two new areas to be included are the vaccination and screening programmes.

There is agreement to include Covid-19 vaccinations in IPQR, this will be fluid and based on relevant cohort. Uptake of flu vaccination will also be included when programme restarts in Autumn. Inclusion in IPQR will replace the production of standalone reports for these topics.

Childhood immunisations for 6-in-1 by 12 months and MMR2 by 5 years are also to be included.

Screening indicators are still being explored.

Public Health and Wellbeing metrics

Smoking Cessation	Retain
CAMHS Waiting Times	Retain
Psychological Therapies Waiting Times	Retain
Alcohol Brief Interventions	Retain
Drugs & Alcohol Treatment Waiting Times	Retain
Dementia Post-Diagnostic Support	Retain
Dementia Referrals	Retain
Covid-19 Vaccination	*NEW*
Flu Vaccination (Sept to Feb)	*NEW*
Childhood immunisation 6-in-1 by 12 months	*NEW*
Childhood immunisation MMR2 by 5 years	*NEW*

Staff Governance

There has been previous discussion about the inclusion of additional metrics in the Staff Governance section. Not all workforce measures lend themselves to routine performance reporting. These will therefore be reported separately e.g. iMatter annual reporting or through provision of Workforce Information reporting introduced in the last year and provided to EDG, Area Partnership Forum and Staff Governance Committee.

However, following discussion at EDG there is agreement that PDPR compliance should be included as soon as possible in addition to our current reporting on Sickness Absence, with discussion already taking place about data availability and visualisation. Core training and Establishment Gap reporting will be explored during 2022/23 for inclusion in due course.

Staff Governance Metrics

Sickness Absence	Retain
PDPR	*NEW*
Core Training	Proposed for future
Establishment Gap	Proposed for future

In terms of Sickness Absence, we note that the existing Board targets were set up to the end of 2021/22, and to date there is no direction about the updating of Scottish Government directed national targets. It is also worth noting the potential implications of any change to the present COVID absence recording and reporting in the course of this year.

2.3.1 Quality/ Patient Care

The IPQR reports on the quality of patient care through a number of core targets, the targets are reported individually.

2.3.2 Workforce

The IPQR currently reports on staff absence rates however it has been agreed that this requires to be developed to report on the important range of activity supporting the health and wellbeing of our staff.

2.3.3 Financial

The IPQR reports on the financial position of the Board, this section is also under development.

2.3.4 Risk Assessment/Management

The IPQR considers organisational risks and there will be a risk section in the IPQR going forward.

2.3.5 Equality and Diversity, including health inequalities

The IPQR considers the appropriate equality and diversity impact.

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

The cross directorate senior leadership group will ensure the appropriate communication and engagement on this review.

2.3.8 Route to the Meeting

A previous version of this paper was considered by EDG on 6 December 2021 and the Board on 26 March 2022.

This second paper has been considered by the IPQR Review Group, EDG on 7 June 2022 and the following committees:

- Clinical Governance Committee – 1 July 2022
- Public Health and Wellbeing Committee – 4 July 2022

2.4 Recommendation

The Committee is invited to

- **Note and agree** to the proposed update to the IPQR from the IPQR Review Group

2.4 Appendices

- Appendix 1: membership of IPQR Review Group

Report Contact

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Planning and Performance Manager
Email: bryan.archibald@nhs.scot

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

Appendix 1: Membership of IPQR Review Group

Bryan Archibald, Planning and Performance Manager

Gemma Couser, Associate Director of Quality and Clinical Governance

Susan Fraser, Associate Director of Planning and Performance (CHAIR)

Ben Hannan, Director of Pharmacy and Medicines

Andy MacKay, Deputy Chief Operating Officer

Fiona McKay, Head of Planning, Fife HSCP

Maxine Michie, Deputy Director of Finance

Emma O'Keefe, Deputy Director of Public Health

Kevin Reith, Deputy Director of Workforce

Nicola Robertson, Associate Director of Nursing

Torfinn Thorbjornsen, Information Services Manager

Arlene Wood, Non Executive Director

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**12 July 2022**
Title:	**Labs Managed Service Contract (MSC) Performance Report**
Responsible Executive:	**Claire Dobson, Director of Acute Services**
Report Author:	**Ken Campbell, Laboratory Services Manager**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan

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

- Effective

2 Report summary

2.1 Situation

This annual report fulfils a recommendation made in an audit report which was presented in August 2019 by the FTF Internal Audit Service on Service Contract Expenditure – Managed Service Agreement for Laboratory Services Report No. B29/19

The scope of the audit was to evaluate and report on controls established to manage the risks relating to the operational governance and financial monitoring of this contract.

This SBAR describes year seven of the contract for 2021/22. The value of the contract for 2021/22 was £2.56m (compared to £2.471m in 2020-21) with VAT savings standing at £512k.

2.2 Background

A Managed Service Contract for Laboratory Services between NHS Fife and Roche Diagnostics was signed in May 2014 with an agreed commencement date of 1st April 2015 for a contract term of seven years, ending in March 2022. The initial contract was developed predominately for Blood Sciences but rapidly developed into a true pan pathology service as Microbiology and Cellular Pathology activity were novated into the contract.

As part of the contract governance NHS Fife receives a monthly financial statement and a quarterly business report from Roche; this is followed up with a review meeting involving key personnel from both parties.

2.3 Assessment

Performance

During years 1-5 of the contract payments were based on an unitary charge incorporating the fixed, semi fixed and variable costs associated with the contract however during year 6 the unitary charge was suspended and payments were based on actual contract activity to ensure that NHS Fife did not make significant overpayments. This decision was based on the dramatic drop in workload in the early stages of the COVID 19 pandemic. During 2021 workload started to recover and in some Laboratory sections significantly exceeded pre-Covid activity. This made forecasting workload activity very difficult and the decision was taken to continue with quarterly payments based on actual activity rather than a projected forecast.

To facilitate financial governance of the contract Roche issued monthly statements which were reviewed by the Head of Laboratory Services and the Finance Business Partner.

Authorised Variations

There were 4 in-year contract change notices (CCNs):

CCN No.	Detail	CCN Value (£)
60	Addition of E&O Reagents	-7,783.00
62	Transfer of Roche SARS-Cov-2 Products into Main Contract	0
63	Addition of Roche Kits for Pre-eclampsia Testing	42,882.02
64	Novation of Cobas B123 and Addition of Service Contract	2500

These are mainly equipment and consumables being moved into the contract. The exception was CCN 63 which was to support a business case from Obstetrics for the introduction of new blood markers for pre-eclampsia and was based on projected full year activity if the service was funded and introduced rather than actual expenditure.

KPI Refunds (service deductions)

Period	Value (£)
Q1	85.56
Q2	2,519.64
Q3	3,194.55
Q4	11,978.75
Total	**17,778.50**

Other key information

NHS Fife is currently transitioning to the new Regional Managed Service contract held by NHS Lothian. Although the primary contract is held by Lothian, NHS Fife and NHS Borders have a Memorandum of Understanding with NHS Lothian accepting financial and governance responsibility for their activity under the new contract. The other main change is how Roche will invoice; we will move to a cost per reportable test as opposed to the unitary charge in the previous contract. This means that we will be charged an agreed amount for each patient result we report. This charge will encompass all costs associated with a given test and allow us to better monitor the cost of the work that we carry out.

The first element of the new contract to be implemented in September 2021 was Blood Transfusion which was not part of the previous Roche MSC but was part of a separate contract. One of the aims of the regional MSC was consolidation of contracts and standardisation of methodology; the next phase will see the replacement of all blood gas analysers on the VHK site. These analysers have been heavily used during the Covid pandemic and are due for replacement but this upgrade will see the introduction of the same instruments right across the region.

It was anticipated that the installation phase of the core Blood Sciences elements of the contract would begin in April 2022 however due a global shortage of micro chips coupled with a loss of productivity during Covid this has been delayed however we have now received a detailed installation plan from Roche and we anticipate this will still be completed by the end of March 2023. We will continue to work closely with colleagues in Procurement and Finance to monitor progress of the implementation.

2.3.1 Quality/ Patient Care

The contract is managed to both meet and evidence the requirements of laboratory accreditation to ISO 15189 as assessed by UKAS.

2.3.2 Workforce

The Roche MSC includes a £10k training budget to support staff training and development.

2.3.3 Financial

This managed service has enabled NHS Fife to realise VAT savings of £512k in year 7 of the contract.

2.3.4 Risk Assessment/Management

Refer to MSC risk assessment (Appendix 3)

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the contract only relates to the provision of equipment, reagents and consumables.

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

Not applicable

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/Roche MSC finance meeting, 17 May 2022
NHS FIFE/Roche MSC review meeting, 25 May 2022

2.4 Recommendation

Assurance – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Audit Report B29/19
- Appendix 2, MSC Business Review Q4
- Appendix 3, Risk Assessment

Report Contact

Ken Campbell
Laboratory Services Manager
ken.campbell2@nhs.scot

FTF Internal Audit Service

Service Contract Expenditure

Managed Service Agreement for Laboratory Services

Report No. B29/19

Issued To: P Hawkins, Chief Executive
C Potter, Director of Finance

G Couser, General Manager (Women, Children, Clinical Services Directorate)
D Galloway, Laboratory Services Manager
J Adamson, Finance Business Partner (Women, Children, Clinical Services Directorate)
K Campbell, Service Manager

E Ryabov, Chief Operating Officer – Acute Services Division
N Connor, Interim Director of Health and Social Care
Follow-Up Co-ordinator
Audit and Risk Committee
External Audit

Contents

Draft Report Issued	6 August 2019
Management Responses Received	22 August 2019
Target Audit & Risk Committee Date	5 September 2019
Final Report Issued	**27 August 2019**

CONTEXT AND SCOPE

1. The NHS Fife Board Strategic Framework includes the objective of "***Clinically Excellent***" which is to:
    - Work with you to receive the best care possible care;
    - Ensure there is no avoidable harm;
    - Achieve and maintain quality standards;
    - Ensure the environment is clean, tidy, well maintained, safe and something to be proud of;
    - Embed patient safety consistently across all aspects of healthcare provision.
2. The NHS Fife Board Assurance Framework (BAF) includes the Quality and Safety Risk which states the following which could threaten the achievement of this strategic objective – '*the risk that due to failure of clinical governance, performance and management systems NHS Fife maybe unable to provide safe, effective person centred care.'*
3. The current mitigations recorded in the BAF to mitigate this risk include:
    - Strategic Framework
    - Clinical Strategy
    - Clinical Governance Structures and operational Governance arrangements
    - Clinical & Care Governance Strategy
    - Participation & Engagement Strategy
    - Risk Management Framework'
4. A Managed Service Agreement for Laboratory Services between NHS Fife Board and the contractor Roche Diagnostics Limited was signed in May 2014, with an agreed commencement date of 31 March 2015 for a contract term of seven years. Laboratory Medicine is part of the Women, Children and Clinical Support Directorate within the Acute Services Division of NHS Fife. Laboratory Medicine consists of four laboratory departments:
    - Clinical Biochemistry
    - Cellular Pathology
    - Haematology with Blood Transfusion
    - Microbiology and Infection Control
5. There is no specific risk recorded in the risk system around this Managed Service Agreement. As part of assessing departmental risks within the NHS Fife Risk Management Framework, consideration should be given to undertaking a risk assessment to ascertain if there is a financial risk or risk of the laboratory contract not performing and affecting operational service requirements,.
6. Internal audit B28D/17 Departmental Review - Laboratories was issued in December 2016, with an audit opinion of Category A – Good. The scope of work was designed to evaluate whether appropriate systems were in place and operating effectively to mitigate risks to the laboratory achieving and maintaining accreditation to the ISO 15189 Standard and identified no further improvements or recommendations.

7. The scope of this review was to evaluate and report on controls established to manage the risks relating to the operational governance and financial monitoring of the Managed Service Agreement for Laboratory Services (the contract). Our audit evaluated the design and operation of the controls and specifically considered whether:

   - The contract will deliver on the original criteria that it was agreed upon;
   - Contract monitoring arrangements will identify all delivery failures resulting in financial clawback and revenue to NHS Fife and facilitate effective service provision;
   - Variations to the contract are checked for inclusion in the contract, appropriately identified, agreed and appropriately costed;
   - There are processes in place to monitor efficiency of the contract.

AUDIT OPINION

8. The Audit Opinion is limited to the operational governance and financial monitoring of the contract, the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.

9. A description of all definitions of assurance and assessment of risks are given Section 3 of this report. The Laboratory Service holds ISO 15189:2012 accreditation in the Blood Science, Cellular Pathology and Microbiology Departments which is monitored and tested by the United Kingdom Accreditation Service (UKAS), this provides robust assurance over operational activities and the contract.

10. We identified appropriate arrangements in place for the monitoring of the performance of the contract with a comprehensive Business Review Report produced and issued quarterly by the contractor to key Senior Management of NHS Fife. This provides clear information on the contract scope and additions, instrument list, unitary charge (fixed cost), Contract Change Notices (CCNs) (variations), statement overview, summary of year to date expenditure against forecast and variation in expenditure and % of expenditure, KPI report, action tracker and minutes of the Quarterly Review meetings. This is further augmented by a quarterly meeting with Senior Management representatives from both NHS Fife and the Contractor to discuss the performance and operations of the contract along with any service issues.

11. We note that a significant advantage of the Managed Service Agreement is the recovery of VAT which provides savings for the Board. NHS Fife receives VAT recovery on the contract, providing savings on the purchase of many laboratory services and consumables. The savings from VAT recovery for 2018/19 was approximately £425K.

12. The main areas identified which present opportunity for improvement are:

- **Variations to the contract**: These are identified and escalated to the Laboratory Service Manager who checks the request against the contract to ensure it is an addition; all variations are recorded on a Contract Change Notice form (CCN). Internal Audit noted that there is no formal authority in place to authorise CCNs, with the exception of the Accounts Payable authorisation list, an integral part of the Financial Operating Procedure and Standing Financial Instructions (SFIs). The CCN values are of significant monetary amounts and the current process is in breach of the SFI authorisation limits. We recommend that this process is reviewed to include a formal authorisation record with authorised expenditure limits and procedures produced to inform all relevant parties before the expenditure on variations is committed.
- **Service Failures/ Faults**: We noted the good practice of independent verification of service failures / faults within the contract by continuous monitoring through the NHS Fife Quality Management System (QMS), Q Pulse. However, there is further scope for the service failures or faults to be independently verified and monitored through to receipt, to ensure that the figures provided by the Contractor are accurate and NHS Fife receive the full value of clawbacks.
- **Clawbacks/ Service Deductions**: The Contractor provides NHS Fife with a record of the service failures and consequent clawback monetary amounts. Currently there is no independent check by NHS Fife of the calculation of the clawback amounts. Management have advised that they have requested and agreed with the Contractor that they will provide a breakdown of clawback payments due. This breakdown will be included in the Quarterly Business Review Report from Q2 of 2019-20. In addition, management have requested further information and transparency of the calculation of the clawback payments to enable independent verification. See Paragraph 23 for further information.

The Managed Service Laboratory Contract

13. The award of the Managed Service Contract in the Laboratories was appropriately approved by the Finance & Resources Committee in November 2013. The Laboratory Service holds ISO 15189:2012 accreditation in the Blood Science, Cellular Pathology and Microbiology Departments which is monitored and tested by the United Kingdom Accreditation Service (UKAS).

14. The Contractor provides a comprehensive Quarterly Business Review Report which includes: contract scope and additions, instrument list, unitary charge (fixed cost), CCNs, statement overview, summary of year to date expenditure against forecast and variation in expenditure and percentage of expenditure, a KPI report and an action tracker.

15. The Quarterly Business Review Report is discussed with the Contractor, the Laboratory Manager, Clinical Staff, Management Accountant and Service Manager at a quarterly meeting. The minutes are recorded from these meetings and included as Appendix 5, in the subsequent Quarterly Business Review Report.

16. The Contractor produces an annual draft service and budgetary forecast, which is then reviewed by the Laboratory Service Manager and the Management Accountant along with input from the relevant Service Managers. A formal annual review is completed and a unitary cost is agreed with the Contractor and invoiced by quarterly instalments.

17. Senior management are kept appraised of the performance of the contract by regular 1:1 meetings where high level discussion takes place between the General Manager and the Laboratory Services Manager. The Laboratory Services Manager is kept informed of the Contractor's performance, including any issues by the Service Managers.

Contract Monitoring Arrangements

18. The quarterly reports supplied by the Contractor have been retrospective with an approximate six week time delay, and therefore the information has not been timely. However, management have advised, that in May 2019, the Contractor introduced a new online system 'Pulse', (this system is distinguished from the NHS Fife Quality Management System Q pulse). The Contractor now provides NHS Fife Senior Management with live data, including expenditure, and this will provide NHS Fife management with the opportunity to obtain data, undertake meaningful analysis and become informed of any issues quickly.

19. The Unitary Contract Payment is appropriately authorised by the Director of Finance. As this payment is significant in value, we recommend that an SBAR is prepared, providing information on the performance of the contract, the variations which have been authorised, Clawbacks/Service Deductions and any other key information for the relevant year before the Unitary Contract Payment is due. This will ensure that the Director of Finance is fully informed of any key issues before the payment is made.

20. Our audit testing confirmed that the identification and recording of service failures on this contract is robust but there is further scope to enhance the process by performing an independent calculation of the value of service failures/faults and monitoring them to ensure that the service deduction is accurate and receipted in a timely manner. The electronic QMS Q pulse is utilised for recording all service failures and faults and is subjected to rigorous testing through the ISO 15189 accreditation process. The ISO standard assesses medical laboratories against specific quality and competence requirements. We selected a random sample of five service failures from the electronic QMS and matched them to the Customer Report Form, utilised by the Contractor for recording and identifying the issue and detailing remedial actions that have been taken to resolve the issue. Our sample testing concluded that all service failures were recorded on the Q3 Business Review Report.

21. The service levels and service points with response times for addressing service failures or faults are included in the contract within Section 8 and Annexes 1-4, Service Delivery is banded by the criticality of the service (A being most critical). Management have advised that if there is an ongoing concern, it is raised and escalated at the Quarterly Service Meeting and this is usually addressed by a Senior Officer from the Contractor visiting the site to rectify the issue. Management have advised that there is a really positive relationship with the Contractor and any faults or service failures are quickly addressed to ensure the smooth running of the service.

22. We note that an appropriate Dispute Resolution section is provided within the contract at section 22 to make clear to the parties the procedure to follow if any disputes arise.

Clawbacks/ Service Deductions

23. The Contractor provides NHS Fife with a record of the service failures and consequent clawback monetary amounts. Currently there is no independent check by NHS Fife of the calculation of the clawback amounts. We reviewed the year to date clawback value supplied by the Contractor to Q3, £31,116.93, and confirmed with Finance that this value has been receipted by the March 2019 monthly statement (transactional statement). The calculation of the value of clawbacks has been discussed with Senior Management. Management sought clarification on how the service failures are calculated by the Contractor and have requested transparency on the calculation of clawback amounts to enable independent verification and ensure that the full amounts due are receipted on a timely basis. Section 8.8 of the contract provides that Service Deductions will be deducted from the value of the next invoice, ***'The sum of all Service Deductions accrued for each Quarterly Period shall be applied to the value of the next invoice issued following the expiry of the relevant Quarterly Period in which the Service Deductions accrued, and delivery of the service report, and which invoice is issued pursuant to Schedule Part 3 (and accordingly the amount of such invoice shall be reduced accordingly.'***

Variations and Contract Change Notifications

24. The formal contract is retained by the Laboratory Service Manager and comprehensive Business Review Reports are produced by the Contractor quarterly to provide a summary of the services provided and CCNs are included within the quarterly report. When a change of contract is requested by a Service, the Laboratory Manager checks the request for reasonableness and reviews the contract to ensure it is not already included. The variation to the contract is discussed at the Quarterly Service Meeting and the Contractor produces a CCN that includes a reference number, the originator, reason for change, details of change, cost of change, schedule of payment, impact on other terms and conditions of contract, expiry date and validation of the CCN.

25. The variations to the contract recorded on the CCNs are of significant monetary value and three out of the five selected for our testing were over the authorised limit for the Accounts Payable limitation of the Budget Holder. We noted that there is no formal authority in place to authorise CCNs and the Finance Department are notified of the CCN retrospectively. It is critical that any variations to the contract are appropriately authorised in line with the SFIs to ensure that the expenditure is appropriately monitored and controlled.

Processes in place to monitor the efficiency of the contract

26. There are appropriate processes in place to monitor the efficiency of the contract which is monitored by quarterly meetings that are informed by the Quarterly Business Review Report. Key Senior Management from NHS Fife and the Contractor attend the Quarterly Service Meeting and these Officers are identified within the Business Review Report. In addition, management information is independently recorded on QMS Q Pulse. The Quarterly Business Review Reports show the planned level of service with the actual service provided and shows top performing products and underperforming products.

27. Management have advised that recent developments have included the introduction of a monthly meeting between the NHS Fife, Finance Business Partner – (Women's, Children and Clinical Services) and the Management Accountant representative from the Contractor.

ACTION

28. The action plan at section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

The Unitary Contract Payment is appropriately authorised by the Director of Finance However, we note that there is no formal update of key changes provided to the Director of Finance before the Unitary Contract Payment is made.

Audit Recommendation:

As this payment is of significant value, we recommend that an SBAR is prepared, providing information on the performance of the contract, the variations which have been authorised, Clawbacks/Service Deductions, if the contract amount has increased or decreased and explanations of the increase or decrease of the contract payment, and any other key information for the relevant year before the Unitary Contract Payment is due, to ensure that the Director of Finance is fully informed of any key issues before the payment is made.

Assessment of Risk:

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

Management Response/Action

Agreed. Discussion will take place with the Director of Finance to ascertain and agree the information to be presented and the detail required for the SBAR which will be presented to the Director of Finance annually before the Unitary Contract Payment is processed.

Action by

Laboratory Service Manager

Date of expected completion:

30 November 2019

Action Point Reference 2

Finding:

Our audit testing confirmed that the identification and recording of service failures on this contract is robust but there is further scope to enhance the process by performing an independent calculation of the monetary value of service failures/faults and monitoring them to ensure that any Service Deductions are receipted on a timely basis**.**

Audit Recommendation:

Internal Audit recommend an independent spot check and that processes are implemented to ensure that clawbacks can be verified and the full amounts due are receipted on a timely basis in line with the contract at Section 8. In addition, we recommend that a retrospective exercise is carried out to ensure that any service failures have been deducted from the quarterly payment in previous years.

Assessment of Risk:

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

Management Response/Action

We have requested and agreed with the Contractor that they will provide a breakdown of clawback payments due and the calculations around these which will be included in the quarterly Business Report from Q2 of 2019-20. This report is expected in November 2019.

We have requested that the Contractor provide transparency around the calculation of the clawback payments to enable NHS Fife to check and verify the amounts and monitor through to receipt.

Action by

Finance Business Partner, Women, Children and Clinical Services Directorate

Date of expected completion:

30 November 2019

Action Point Reference 3

Finding:

The variations to the contract recorded on the CCNs are of significant monetary value and three out of the five selected from our testing were in breach of the SFIs, an integral part of the Code of Corporate Governance. We noted that there is no formal authority in place to authorise CCNs, with the exception of the Accounts Payable authorisation list, an integral part of the Financial Operating Procedure and SFIs. It is critical that any variations to the contract are appropriately authorised in line with the SFIs to ensure that the expenditure is appropriately monitored and controlled.

Audit Recommendation:

Internal Audit recommend that the process for the authorisation of CCNs is reviewed and should include formal authority and a procedure to ensure that all relevant parties are informed of the change and the expenditure is monitored and controlled.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action

Agreed, discussion will take place with the Director of Finance around the current process to agree changes which, going forward will ensure that variations to the contract are appropriately authorised in line with SFIs.

Action by

Laboratory Service Manager

Date of expected completion:

30 November 2019

Action Point Reference 4

Finding:

We note that the Managed Service Agreement is of significant monetary value and is a critical service of the functioning of NHS Fife Health Board, but it is not recorded on a departmental risk register.

Audit Recommendation:

Consideration should be given to undertaking a risk assessment to see if there is a financial risk or risk of the laboratory contract not performing and effecting operational service requirements as part of assessing departmental risks within the NHS Fife Risk Management Framework.

Assessment of Risk:

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

Management Response/Action

Agreed, an internal risk assessment will be performed, held within the Laboratory Quality Management System and reviewed on a yearly basis.

Action by

Service Manager (Blood Transfusion, Clinical Biochemistry and Haematology)

Date of expected completion:

30 November 2019

Section 3 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Section 3 Definition of Assurance and Recommendation Priorities

Assessment of Risk

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

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	0
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	1
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	3

Optim*all* Managed Pathology Service Business Review Report – Q4 2021/2022

NHS Fife

Optim*all* Managed Pathology Service
Business Review Report – Q4 2021/2022
NHS Fife

Executive Summary

The Roche Managed Service Contract for Fife NHS Health Board is in year seven. The contract signed in May 2014 with the agreed commencement date being 31st March 2015. The contract term is 7 years.
The service provision expected to extend within the contract terms and scope to include all departments and disciplines with the NHS Fife pathology service.

The value of the contract for 2021_22 is £2.56 m due to the inclusion of additional services and tests. The potential VAT saving now stands at £512k.

Table of Contents

1. Contract Overview

1.1. Contract Scope and additions

Provision of fully managed laboratory services to enable the delivery of all blood based assays performed by NHS Fife's Pathology laboratories. The contract initially included tests performed within Clinical Biochemistry, Hematology (including Coagulation) and Serology (including Immunology).
The scope has extended within the contract term to include, without limitation, Cellular Pathology, Microbiology and Molecular diagnostics.

Contract Start Date 1st April 2015
Contract Term: 7 Years to 31st March 2022

1.2. Indexation Term

The CPI as published by the ONS in January, each contract year, for the preceding 12 months will form the basis for the annual price review for the Managed Service Contract.

0.6% indexation 2021-2022

1.3. Contract Governance Structure

NHS Fife

Name	Role	Contact Details
Donna Galloway	Clinical Director – Women, Children & Clinical Services	Donna.Galloway3@nhs.scot 01592 648102
Ken Campbell	Laboratory Services Manager	Ken.Campbell2@nhs.scot 01592 648005
David McLean	Interim Blood Science Service Manager	David.Mclean@nhs.scot 01592 729475
Sarah Dack	Service Manager – Blood Sciences	Sarah.Dack@nhs.scot 01592 729987
Stephen McGlashan	Service Manager – Microbiology	Stephen.Mcglashan@nhs.scot 01592 648095
Derek Selbie	Service Manager – Pathology	Derek.Selbie@nhs.scot 01592 648095
Heather Holmes	Consultant Clinical Biochemist	Heather.Holmes@nhs.scot 01592 648174
Jacqueline Adamson	Management Accountant	Jacqueline.Adamson@nhs.scot 01592 643355
Lisa Logan	BMS Manager - Microbiology	Lisa.Logan@nhs.scot 01592 648157

Roche Diagnostics Ltd

Name	Role	Responsibility	Contact Number
Lesley Hawthorn	Regional Customer Account Manager – North	Regional Manager	lesley.hawthorn@roche.com 07740 735 270
Maureen Polson	Customer Account Manager	Responsible for all aspects of the contract	maureen.polson@roche.com 07738 028507
Emma Westwick	Customer Account Manager	Responsible for all aspects of the contract	Emma.Westwick@roche.com 07793 267112
Jenna Robertson	CS Sales Specialist	Roche Centralised Solutions	Jenna.Robertson@roche.com 07764 660630
Lee McMullen	CPS Team	Roche Point of Care	lee.mcmullen@roche.com 07712 548 642
Garry Cusack	Molecular System Account Manager	Roche Molecular	garry.cusack@roche.com 07841 363742
Connor Roddie	Tissue Diagnostics Sales	Roche Tissue Diagnostics	Connor.Roddie@roche.com 07802 860 894
Shannen Hawkes	Commercial Finance Business Partner	Financial Reporting & Analysis	Shannen.Hawkes@roche.com 01444 256 846
Chris Catty	Senior Contract Lifecycle Specialist	KPI Reporting & Change Control	01444 256862 chris.catty@roche.com

1.4. Instrument List

Instrument which have been fully implemented on the basis of a signed acceptance form

Supplier	Location/Department	Model	Serial Number	Service Level	Renewal Date
Roche Pre Analytics	Victoria Hospital - Biochemistry	c8100	1404-04	Comprehensive	31-03-2023
Roche Chemistry		c702 module	14A3-05	Comprehensive	31-03-2023
		c702 module	14A4-05	Comprehensive	31-03-2023
		c 502 module	1477-09	Comprehensive	31-03-2023
Roche Immunoassay		e 602 module	1490-12	Comprehensive	31-03-2023
		e 602 module	1494-06	Comprehensive	31-03-2023
		e 602 module	1495-10	Comprehensive	31-03-2023
Roche Post Analytics		p501	1047	Comprehensive	31-03-2023
Roche Molecular	Victoria Hospital - Microbiology	cobas x 480	3876	Comprehensive	31-03-2023
		cobas z 480	50183	Comprehensive	31-03-2023
		MagNa Pure Compact Instrument	MPCB0921	Comprehensive	31-03-2023
Roche Tissue	Victoria Hospital - Histopathology	BENCHMARK ULTRA STAINER	313539	Comprehensive	31-03-2023
		BENCHMARK ULTRA STAINER	313575	Comprehensive	31-03-2023
Roche Blood Gas	Victoria Hospital - TBC	cobas b 123	13041	Comprehensive	31-03-2023
		cobas b 123	13052	Comprehensive	31-03-2023
		cobas b 123	13047	Comprehensive	31-03-2023
		cobas b 123	13054	Comprehensive	31-03-2023
		cobas b 123	13104	Comprehensive	31-03-2023
		cobas b 123	13098	Comprehensive	31-03-2023
		cobas b 123	13158	Comprehensive	31-03-2023
		cobas b 123	13207	Comprehensive	31-03-2023
		cobas b 123	13171	Comprehensive	31-03-2023
		cobas b 123	13163	Comprehensive	31-03-2023
BD	Victoria Hospital - Microbiology	BACTEC FX	FT0119	Comprehensive	31-03-2023
		BACTEC FX	FB0077	Comprehensive	31-03-2023
		BACTEC FX	FT2991	Comprehensive	31-03-2023
Biomerieux		Vitek V2	2XL4192	Comprehensive	31-08-2022
		Vitek MS	51185	Comprehensive	31-08-2022
		MYLA	C23512T51H	Comprehensive	31-08-2022
DiaSorin	Victoria Hospital - Serology	Liaison XL	2210001922	Comprehensive	30-11-2022
Launch	Victoria Hospital - Microbiology	DS2	1DSA0289	Comprehensive	30-09-2022
Nikon	Victoria Hospital - Haematology	ECLIPSE Ci-L	704836	N/a	On lab contract
		ECLIPSE Ci-L	704788	N/a	On lab contract
NorthStar	Victoria Hospital - Biochemistry	UVIKON XS	421	Comprehensive	07-12-2022

Supplier	Location/Department	Model	Serial Number	Service Level	Renewal Date
Panasonic	Victoria Hospital- South Laboratory	Medical/Pharma Fridge 486L	16120542	PMI & Call out as required	01-12-2022
	Victoria Hospital- South Laboratory	PMedical/Pharma Fridge 486L	16120558	PMi & Call out as required	01-12-2022
Point of Care Testing	Victoria Hospital - Biochemistry	Piccolo Xpress	P20233	Call out as and when required	N/a
Sebia	Victoria Hospital - Biochemistry	Hydrasys 2	1690	Comprehensive	30-09-2022
		Capillarys 2	3554	Comprehensive	30-09-2022
Sysmex	Victoria Hospital - Haematology	XN9000	Fife1	Comprehensive	30-10-2022
		XN 10	15866	Comprehensive	31-10-2022
		XN 10	15867	Comprehensive	31-10-2022
		XN 10	15868	Comprehensive	31-10-2022
		TS500	6008321	Comprehensive	31-10-2022
		RPU	050052	Comprehensive	31-10-2022
		Inversa	046954	Comprehensive	31-10-2022
		SP10	1185	Comprehensive	31-10-2022
		EPU	PC1	Comprehensive	31-10-2022
		EPU	PC2	Comprehensive	31-10-2022
		EPU	PC3	Comprehensive	31-10-2022
		CS5100	11751	Comprehensive	30-11-2022
		CS5100	11752	Comprehensive	30-11-2022
		G8 Tracked	13423304	Comprehensive	31-10-2022
		G8 (standalone)	13884803	Comprehensive	31-10-2022
		GX	10322909	Comprehensive	31-10-2022
	Queen Margaret Hospital	XS100	71310	Comprehensive	31-10-2022
		GX	10322809	Comprehensive	31-10-2022
Thermo	Victoria Hospital - Biochemistry	GCMS	715000114	Comprehensive	10-03-2023
Vitech	Victoria Hospital - Biochemistry	Advanced Osmometer	13105673B	Comprehensive	27-10-2022
Werfen	Victoria Hospital - Immunology	DS2 Elisa Processor	1DSA1537	Comprehensive	31-12-2022
		OLYMPUS CX41 Fluro Microscope & Camera	4M43318	N/a	

2. Financial Performance

2.1. Unitary Charge 2021_22

	Forecast	Budget	Variance
Fixed	203,654	203,654	-
Semi-Fixed	184,089	184,089	-
Management Fee	36,042	36,042	-
MLS Sundries	**423,785**	**423,785**	**-**
Roche Centralised Solutions (RCS)	690,720	690,720	-
Roche Molecular Diagnostics (RMD)	39,417	39,417	-
Roche Point of Care (POC)	225,822	225,822	-
Roche Tissue diagnostics (RTD)	94,806	94,806	-
ABBOTT RAPID DIAGNOSTICS LTD	549	549	-
ADVANCED INSTRUMENTS LTD	3,057	3,057	-
ALPHA LABORATORIES LTD	1,031	1,031	-
BECTON DICKINSON UK LTD	52,305	52,305	-
BIO-RAD LABORATORIES LTD	9,271	9,271	-
BIOMERIEUX UK LTD	72,786	72,786	-
CAMBRIDGE LIFE SCIENCES LTD	753	753	-
CELLPATH LTD	4,835	4,835	-
DIASORIN LTD	69,604	69,604	-
FISHER SCIENTIFIC UK LTD	1,701	1,701	-
LAUNCH DIAGNOSTICS LTD	40,438	40,438	-

LEICA MICROSYSTEMS UK LTD	17,505	17,505	-
MERCK LIFE SCIENCE UK LTD	328	328	-
NORTHSTAR SCIENTIFIC LTD	654	654	-
PRO-LAB DIAGNOSTICS	128	128	-
PROTECH MEDICAL LTD	1,393	1,393	-
QIAGEN LTD	357,468	357,468	-
SARSTEDT LTD	11,186	11,186	-
SEBIA UK LTD	33,373	33,373	-
SHANDON DIAGNOSTICS LTD	2,864	2,864	-
SYSMEX UK LTD	278,939	278,939	-
TCS BIOSCIENCES LTD	133	133	-
TECHNOPATH	18,560	18,560	-
THERMO ELECTRON MANUFACTURING LTD	5,196	5,196	-
THERMO MICROGENICS	6,085	6,085	-
THERMO OXOID	70,765	70,765	-
TRINITY BIOTECH PLC	707	707	-
WERFEN	23,980	23,980	-
Variable Spend	**2,136,358**	**2,136,358**	**-**
Total	**2,560,143**	**2,560,143**	**-**

2.2. In Year CCN

CCN No.	CCN Title	CCN Signature Date	Total Cost p.a	VAT Savings
CCN 60	Addition of E&O Reagents	11/05/2021	-£7,783.00	-£1,556.60
CCN62	Transfer of Roche SARS-Cov-2 Products into Main Contract	13/05/2021	£0.00	£0.00
CCN 63	Addition of Roche Kits for Pre-eclampsia Testing	25/05/2021	£42,882.02	£8,576.40
CCN 064	Novation of Cobas B123 and Addition of Service Contract	21/06/2021	£2,500.00	£500.00

See Appendix 2 for full list of contract change notices (CCN's)

2.3. Pending CCN

CCN No.	Date Requested	CCN Title	Date Issued

2.4. Pending IAF

CCN No.	Vendor Name	CCN Title	IAF Status

To be Drafted: IAF required confirmation needed that IAF can be released.
Released: IAF sent to CAM or Trust for action.

2.5. Statement Overview

Financial Position	Value
Opening Balance	(939,070)
Total Invoices/Credits YTD	2,481,043
Total Charges YTD	(2,361,654)
Closing Balance	**(819,681)**

2.6. Summary YTD Expenditure

Vendor Summary	Act YTD	Bud YTD	Var. YTD	Proj. FY	Bud FY	Var. Proj.	FY Budget	Open Orders
Fixed	203,654	203,654	-	203,654	203,654	-	203,654	-
Semi-Fixed	186,173	184,089	(2,083)	186,173	184,089	(2,083)	184,089	-
Management Fee	36,042	36,042	-	36,042	36,042	-	36,042	-
KPI Credits	(6,491)	-	6,491	(6,491)	-	6,491	-	-
MLS Sundries	**419,378**	**423,785**	**4,408**	**419,378**	**423,785**	**4,408**	**423,785**	**-**
Roche Centralised Solutions (RCS)	724,091	688,595	(35,496)	724,091	688,595	(35,496)	688,595	333
Roche Molecular Diagnostics (RMD)	19,007	39,417	20,411	19,007	39,417	20,411	39,417	-
Roche Point of Care (POC)	185,750	226,507	40,757	185,750	226,507	40,757	226,507	4,253
Roche Tissue diagnostics (RTD)	96,257	94,806	(1,451)	96,257	94,806	(1,451)	94,806	694
ABBOTT RAPID DIAGNOSTICS LTD	618	549	(69)	618	549	(69)	549	-
ADVANCED INSTRUMENTS LTD	7,534	9,221	1,687	7,534	9,221	1,687	9,221	-
ALPHA LABORATORIES LTD	2,014	1,031	(983)	2,014	1,031	(983)	1,031	-
BECTON DICKINSON UK LTD	44,830	52,305	7,476	44,830	52,305	7,476	52,305	-
BIO-RAD LABORATORIES LTD	3,315	10,612	7,297	3,315	10,612	7,297	10,612	-
BIOMERIEUX UK LTD	89,413	72,786	(16,628)	89,413	72,786	(16,628)	72,786	6,179
CAMBRIDGE LIFE SCIENCES LTD	1,877	753	(1,124)	1,877	753	(1,124)	753	-
CELLPATH LTD	4,345	4,835	489	4,345	4,835	489	4,835	136
DIASORIN LTD	65,523	69,604	4,081	65,523	69,604	4,081	69,604	3,287
E&O LABORATORIES LTD	34,095	-	(34,095)	34,095	-	(34,095)	-	911
FISHER SCIENTIFIC UK LTD	739	1,701	961	739	1,701	961	1,701	151

LAUNCH DIAGNOSTICS LTD	37,089	40,438	3,349	37,089	40,438	3,349	40,438	6,019
LEICA MICROSYSTEMS UK LTD	14,047	17,505	3,457	14,047	17,505	3,457	17,505	506
MAST GROUP LTD	2,915	-	(2,915)	2,915	-	(2,915)	-	996
NORTHSTAR SCIENTIFIC LTD	654	654	-	654	654	-	654	-
PRO-LAB DIAGNOSTICS	2,630	128	(2,502)	2,630	128	(2,502)	128	195
PROTECH MEDICAL LTD	1,404	1,393	(12)	1,404	1,393	(12)	1,393	8
QIAGEN LTD	186,167	357,468	171,301	186,167	357,468	171,301	357,468	5,199
RANDOX LABORATORIES LTD	294	-	(294)	294	-	(294)	-	-
SARSTEDT LTD	11,671	11,186	(486)	11,671	11,186	(486)	11,186	-
SEBIA UK LTD	26,565	33,373	6,808	26,565	33,373	6,808	33,373	-
SHANDON DIAGNOSTICS LTD	5,012	2,864	(2,148)	5,012	2,864	(2,148)	2,864	-
SIGMA-ALDRICH COMPANY LTD	-	328	328	-	328	328	328	-
SYSMEX UK LTD	299,632	272,875	(26,757)	299,632	272,875	(26,757)	272,875	27,767
TCS BIOSCIENCES LTD	82	133	51	82	133	51	133	68
TECHNOPATH	26,240	18,560	(7,680)	26,240	18,560	(7,680)	18,560	-
THERMO ELECTRON MANUFACTURING LTD	407	5,196	4,789	407	5,196	4,789	5,196	419
THERMO MICROGENICS	4,874	6,085	1,212	4,874	6,085	1,212	6,085	384
THERMO OXOID	37,235	70,849	33,615	37,235	70,849	33,615	70,849	386
TRINITY BIOTECH PLC	890	707	(183)	890	707	(183)	707	-
WERFEN	5,060	23,980	18,921	5,060	23,980	18,921	23,980	210
Variable	**1,942,276**	**2,136,442**	**194,167**	**1,942,276**	**2,136,442**	**194,167**	**2,136,442**	**58,101**
Total	**2,361,654**	**2,560,227**	**198,575**	**2,361,654**	**2,560,227**	**198,575**	**2,560,227**	**58,101**

2.7. Aged Open Orders

Aged Open Orders	365+ Days	181 - 365 Days	91 - 180 Days	0 - 90 Days	Total	As a %
BIOMERIEUX UK LTD	-	-	-	6,179	**6,179**	10.6%
CELLPATH LTD	-	-	-	136	**136**	0.2%
DIASORIN LTD	-	-	-	3,287	**3,287**	5.7%
E&O LABORATORIES LTD	-	-	-	911	**911**	1.6%
FISHER SCIENTIFIC UK LTD	-	-	-	151	**151**	0.3%
LAUNCH DIAGNOSTICS LTD	-	-	-	6,019	**6,019**	10.4%
LEICA MICROSYSTEMS UK LTD	-	-	-	506	**506**	0.9%
MAST GROUP LTD	-	-	-	996	**996**	1.7%
PRO-LAB DIAGNOSTICS	-	-	-	195	**195**	0.3%
PROTECH MEDICAL LTD	-	-	-	8	**8**	0.0%
QIAGEN LTD	-	-	-	5,199	**5,199**	8.9%
ROCHE CENTRALISED SOLUTIONS (RCS)	-	-	-	333	**333**	0.6%
ROCHE POINT OF CARE (POC)	-	-	-	4,253	**4,253**	7.3%
ROCHE TISSUE DIAGNOSTICS (RTD)	-	-	-	694	**694**	1.2%
SYSMEX UK LTD	-	-	-	27,767	**27,767**	47.8%
TCS BIOSCIENCES LTD	-	-	-	68	**68**	0.1%
THERMO ELECTRON MANUFACTURING LTD	-	-	-	419	**419**	0.7%
THERMO MICROGENICS	-	-	-	384	**384**	0.7%
THERMO OXOID	-	-	-	386	**386**	0.7%
WERFEN	-	-	-	210	**210**	0.4%
Total	**-**	**-**	**-**	**58,101**	**58,101**	**100.0%**
As a %	**-**	**-**	**-**	**100.0%**	**100.0%**	

2.8. Over & Under Expenditure – Products

Roche Top 10 Over Performing Product Lines

	Business Area	Product Line	YTD Act	YTD Bud	Var.
1	ROCHE CENTRALISED SOLUTIONS (RCS)	Anti-HCV	£12,965	-	(£12,965)
2	ROCHE CENTRALISED SOLUTIONS (RCS)	Anti-SARS-CoV-2	£9,636	-	(£9,636)
3	ROCHE CENTRALISED SOLUTIONS (RCS)	TRANS	£16,817	£8,888	(£7,929)
4	ROCHE POINT OF CARE (POC)	GLU	£65,400	£57,632	(£7,769)
5	ROCHE CENTRALISED SOLUTIONS (RCS)	sFLT1	£7,438	-	(£7,438)
6	ROCHE CENTRALISED SOLUTIONS (RCS)	PIGF	£7,438	-	(£7,438)
7	ROCHE MOLECULAR DIAGNOSTICS (RMD)	CINtec histology	£10,509	£3,503	(£7,006)
8	ROCHE CENTRALISED SOLUTIONS (RCS)	B12	£25,527	£19,211	(£6,317)
9	ROCHE CENTRALISED SOLUTIONS (RCS)	ProBNP	£14,252	£8,540	(£5,712)
10	ROCHE CENTRALISED SOLUTIONS (RCS)	FOLATE	£23,714	£18,538	(£5,176)

	Business Area	Product Line	YTD Act	YTD Bud	Var.
1	ROCHE POINT OF CARE (POC)	cobas b 123 <1>	£96,387	£149,909	£53,522
2	ROCHE MOLECULAR DIAGNOSTICS (RMD)	Influenza A/B & RSV qual.	£6,848	£35,914	£29,066
3	ROCHE CENTRALISED SOLUTIONS (RCS)	MODULAR Pre Analytics	£16,988	£23,296	£6,308
4	ROCHE CENTRALISED SOLUTIONS (RCS)	EDDP	£993	£6,980	£5,987
5	ROCHE CENTRALISED SOLUTIONS (RCS)	HIV combi	£20,094	£24,890	£4,796
6	ROCHE CENTRALISED SOLUTIONS (RCS)	NDC Compensation	(£4,623)	-	£4,623
7	ROCHE TISSUE DIAGNOSTICS (RTD)	OptiView	£37,783	£41,981	£4,198
8	ROCHE CENTRALISED SOLUTIONS (RCS)	AMP	£720	£4,537	£3,817
9	ROCHE CENTRALISED SOLUTIONS (RCS)	THC	£1,224	£4,825	£3,600
10	ROCHE CENTRALISED SOLUTIONS (RCS)	Syphilis	£11,448	£14,834	£3,386

Third Party Top 10 Over Performing Products

	Vendor	Product Description	YTD Act	YTD Bud	Var.
1	LAUNCH DIAGNOSTICS LTD	Helicobacter Stool Antigen	£21,876	£5,316	(£16,560)
2	E&O LABORATORIES LTD	COLUMBIA AGAR & HORSE BLDx10 PP0120-P090	£12,547	-	(£12,547)
3	E&O LABORATORIES LTD	PRIMARY UTIx10 (PP3005-P090)	£11,132	-	(£11,132)
4	SYSMEX UK LTD	INNOVANCE D-Dimer 300 Tests	£31,004	£20,910	(£10,094)
5	LEICA MICROSYSTEMS UK LTD	low-profile disp Blades (10 x 50) DB80LX	£9,046	-	(£9,046)
6	LAUNCH DIAGNOSTICS LTD	Premier C Difficile GDH	£10,980	£2,729	(£8,252)
7	DIASORIN LTD	LIAISON tTG IgA	£29,410	£21,192	(£8,218)
8	SEBIA UK LTD	HYDRAGEL 4 IF (VIOLET ACIDE) s(MS)	£7,373	£461	(£6,913)
9	QIAGEN LTD	eNAT collection Kit 300	£39,098	£32,962	(£6,137)
10	BIOMERIEUX UK LTD	VITEK MS Slides (DS) (32 Slides (8 x 4)	£21,636	£15,533	(£6,102)

Third Party Top 10 Under Performing Products

	Vendor	Product Description	YTD Act	YTD Bud	Var.
1	QIAGEN LTD	artus CT/NG QS-RSQ Kit 96	£82,489	£175,245	£92,755
2	LAUNCH DIAGNOSTICS LTD	FTD Respiratory pathogens (64)	-	£30,857	£30,857
3	QIAGEN LTD	artus HSV-1/2 QS-RSG kit 24	£11,068	£39,845	£28,777
4	QIAGEN LTD	QIAsymphony DSP Virus/Pathogen Midi Kit	£30,509	£51,865	£21,356
5	QIAGEN LTD	artus VZV Qs-RGQ kit 24	£9,685	£29,884	£20,199
6	WERFEN	Monolisa HCV Ag-Ab ULTRA Version 2	£4,009	£22,720	£18,711
7	QIAGEN LTD	artus Hadv RG PCR Kit 96	£13,318	£26,636	£13,318
8	THERMO OXOID	COLUMBIA AGAR + HORSE BLOOD (ORIGINAL)	£19	£11,116	£11,097
9	THERMO OXOID	Brilliance UTI Clarity Agar (10x90mm)	-	£10,347	£10,347
10	SEBIA UK LTD	MAXI-KIT HYDRAGEL 4 IF (MS)	-	£8,335	£8,335

2.9. Annual Training Fund

2015/16	Annual Fixed Fund
Annual Fund	**£10,000.00**
IBMS Congress	£6,445.70
TOSOH User Group	£236.88
NEQAS Course	£714.00
Heamatology Books	£194.00
Pathology Books	£2000.00
Balance	**£409.42**

2016/17	Annual Fixed Fund
Annual Fund	**£10,000.00**
Clincal - Eastbourne (AAPT)	408.50
BBTS Annual Conference	1,074.80
SQMDG Glasgow	681.17
IBMS Portfolio	125.00
SAH 38th Scientific Meeting	20.00
SAH 38th Scientific Meeting	20.00
Thermo Electron On Site Training	1,456.56
Benson Viscometer Training	275.00
Don Whitley Course Micro of Anaerobes	467.58
Mortuary PC & Software (IT No 107480)	761.06
IBMS Course	650.00
Tutorcare First Aid Course	481.00
Corporate Travel Management (Clinisys Winter User Group)	656.80
MAS (UK) Ltd (6 Books)	99.00
New PC Micro S McGlashan (IT No 116857)	5,601.46
Invoice F0026558 Submitted	**£10,000.00**
Balance	**£0.00**

2017/18	Associated PO	Annual Fixed Fund
Annual Fund		**£10,000.00**
Invoice F0031106	PO 6500322595	5995.63
Invoice F0031107	PO 6500322595	682.96
Invoice F0031167	PO 6500322595	850.00
Balance		**£2,471.41**
Closing Balance 31 March 2018		**£0.00**

2018/19	Associated PO	Annual Fixed Fund
Annual Fund		**£10,000.00**
Invoice F0032381	PO 6500334985	£1,500.00
Invoice F0033447	PO 6500362601	£2,769.34
Balance		**£5731.00**
Pending	PO requested - £5,731.00, (balance of training fund)	
Closing Balance 31 March 2019		**£0.00**

2019/2020	Associated PO	Annual Fixed Fund
Annual Fund		**£10,000.00**
Invoice 4460121363		£564.00
Invoice 4460121368		£210.00
Invoice 4460121465		£323.52
Recharge R&D		£300.00
Balance		**£8602.48**
Closing Balance 31 March 2020		**£8602.48**

2020/2021	Associated PO	Annual Fixed Fund
Annual Fund		**£10,000.00**
Tomlinson Books FLS350391 (£109.20)		£9,890.80
Elite Book FES389915 (£6,790.00)		£3,100.80
Certificate of Expert Practice in Leadership FLS402453 (£685)		£2,415.80
Certificate of Expert Practice in Leadership FLS402676 (£685)		£1,730.80
Certificate of Expert Practice in Leadership FLS07892 (£685)		£1,045.80
Invoice (£8,954.20)	PO 6500509662	
Balance		**£1,045.80**
Closing Balance 31 March 2021		**£1,045.80**

2021/2022	Associated PO	Annual Fixed Fund
Annual Fund		**£10,000.00**
NHSF-35 Test Directory Functionality		£4,320.00
16th Annual Education Event 25/09/21	FLS476455	£370.00
IBMS Congress 14-17 March 2022	FLS479615	£383.33
IBMS Congress 14-17 March 2022	FLS479615	£766.67
IBMS Congress 14-17 March 2022	FLS479615	£962.50
IBMS Congress 14-17 March 2022	FLS479615	£641.67
Balance		**£2,555.83**
Closing Balance 31 March 2022		**£2,555.83**

2.10. Lab Enabling Fund

2016/17	Annual Fixed Fund
Annual Fund	**£12,000.00**
Specialist Refurbishing Services	£8,250.00
CCN029 AIRCO Ltd (yr 1/5) 01/11/2016 Charges to expire 31/10/2021	(£4,679.40 pro rata) £1,949,75
CCN030 Enabling Works (yr 1/5) 01.11.2016 Charges to expire 31/10/2021	(£1,650 pro rata) £687.5
Balance	**£1,112.75**
2019/20	**Annual Fixed Fund**
Annual Fund	**£12,000.00**
CCN050 Air Con for Histology	£2045.29
CCN054 Addition of Fridge	£3517.27
Enabling Works Sysmex	800.00
Balance	**£5637.44**

2020/21	Annual Fixed Fund
Annual Fund	**£12,000.00**
Enabling works Microbiology NHS Fife to undertake the work	£3472.00
Balance	**£8528.00**
2021/22	**Annual Fixed Fund**
Annual Fund	**£12,000.00**
Supply and Installation of Drain	£380.00
Balance	**£11,620.00**

3. Performance Review Q4 2021_22

3.1. KPI Report – Measures by the Trust

KPI	Target	Data from Trust	Investigation response
KPI 1 – Urgent Test TAT	90%	None reported	

3.2. KPI's by Exception– Measured by Roche

Vendor	KPI Name	Pass Target	Score	Comments
DIASORIN LTD	Complete System Downtime	**100.00%**	**96.58%**	One repair call in this period
DIASORIN LTD	Fault Response - Band B	**100.00%**	**0.00%**	Was not on site by 6pm the next day as parts were required to be ordered and delivery delayed fixing instrument
Roche Diagnostics Ltd	Engineering Response Times	**100.00%**	**63.16%**	7 of 19 Failed
SEBIA (UK) LTD	Fault Response - Band C	**100.00%**	**0.00%**	2 calls on a Thursday and engineer on site on Monday. Analyser not down on either occasion and results produced.
SYSMEX UK LTD	Fault Response - Band A	**100.00%**	**67.00%**	2 calls failed - FSE availability 9 calls only 2 FSE, & XN9 move only 2 FSE's

For full list of KPI scores see Appendix 5

Roche Engineering Response – Band A:

Case Number	Time (H:MM)	1st Reported Time	Arrival Time	Site Name	Instrument	Serial Number
CAS-0014723538-1	31:57:00	06/01/2022 11:03	12/01/2022 07:30	Victoria Hospital Clinical Biochemistry South Laboratory	cobas p 501 Post-Analytical Unit	AM1047
CAS-0014834716-1	15:42:00	26/01/2022 14:48	28/01/2022 13:30	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8100v2 FiFe Vict. Upgr. (UK)	DO1508-05
CAS-0014883079-1	16:49:00	04/02/2022 09:11	08/02/2022 07:30	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8100v2 FiFe Vict. Upgr. (UK)	DO1508-05

CAS-0014935447-1	11:41:00	14/02/2022 14:19	16/02/2022 07:30	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8100v2 FiFe Vict. Upgr. (UK)	DO1508-05
CAS-0014990597-1	20:50:00	23/02/2022 13:40	28/02/2022 08:00	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8100v2 FiFe Vict. Upgr. (UK)	DO1508-05
CAS-0015080366-1	15:36:00	11/03/2022 12:24	15/03/2022 11:00	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8100v2 FiFe Vict. Upgr. (UK)	DO1508-05
CAS-0015090233-1	08:11:00	14/03/2022 09:19	15/03/2022 08:00	Victoria Hospital Clinical Biochemistry South Laboratory	cobas 8000 cobas c 502 module	AK1477-09

KPI Refund Calculation 2021_2022

Period 21-22	Supplier	Fail	Time Overdue	Service Points	Value
Q1	Roche	**Fault Response – Band A**	3hrs 30min	24	£85.56
Q2	Roche	**Fault Response – Band A**	1hrs 30min	8	£18.38
Q2	Roche	**Complete System Downtime TD**	52hrs 00min	260	£2404.16
Q2	Sysmex	**Fault Response – Band A**	2 hrs 0mins	16	£48.50
Q2	Sysmex	**Fault Response = Band B**	2 hrs 30mins	16	£48.50
Q3	Roche	**Fault Response – Band A**	11hrs 25min	88	£527.56
Q3	Roche	**Fault Response – Band B**	35hrs 30 mins	280	£2,666.99
Q4	Roche	**Fault Response – Band A**	74 hrs	592	£7,607.65
Q4	DiaSorin	**Complete System Downtime**	20 hrs	300	£2,937.45
Q4	DiaSorin	**Fault Response – Band B**	10.5 hrs	84	£494.30
Q4	Sebia	**Fault Response – Band C**	5.5 hrs	44	£199.91
Q4	Sysmex	**Fault Response – Band A**	14 hrs	112	£739.44

Safety Notifications

"A Safety Board Notification / Field Safety Notification provides actions / information related to product quality issues, regulatory issues, field safety corrective actions or other Safety Board related topics and is typically associated with a risk to patient health. Roche has a regulatory obligation to inform our customers about the issue described/reported in a timely and efficient manner. Therefore, from a regulatory point of view, it is vital that each customer provides Roche with the location of all devices in the primary and secondary care settings to ensure notices are sent to the responsible person, within a customer site, to implement the actions stated in the notice."

Appendix 1 – Action Tracker

Number	Date	Action	Owner	Due Date	Status
1	Feb 2015	Provide additional documentation detailing credited impact on 'overspend	VT		Complete
2	Feb 2015	Confirmation tha Menarini invoiced at Tendered pricing	LH		Complete
3	Feb 2015	Outstanding Clynisis invoice credited to NHS Fife now for payment by NHS Fife	OG		Complete
4	Feb 2015	Confirmation of contract terms relating stock ownership and payment	LH/GK		Complete
5	Feb 2015	Confirmation if prolonged line failure had been captured in KPI's	NO		Complete
6	Feb 2015	Timescale for completion of remedial work on dark room	PT		Complete
7	Feb 2015	Review of Serology workflow	SC		Complete
8	Feb 2015 Feb 2015	Dates for software upgrade to cITM for c8100 V2 and dashboards	NO		Complete
9	Feb 2015	GCMS to be removed	LH		Complete
10	Aug 2015	Lack of service reports by Sysmex/Tosoh following site visit	LH		Complete
11	Aug 2015	PO required for PoC IT module	GH		Complete
12	Aug 2015	Further cIMS training request	GB		Complete
13	Aug 2015	Further info required to complete Oxoid Cultiloop CCN	SM		Complete
14	Aug 2015	Novation of Launch in contract	LH/OG		Complete
15	Aug 2015	Novation of BD into contract	LH/OG		Complete
16	Nov 2015	PO to be raised for overspend	MG		Complete
17	Nov 2015	Invoices for cross charging to 'Training Fund' to be submitted to Roche	DG/MG		Complete
18	Nov 2015	Sebia & B Thal's confirm if forecast is correct	LH		Complete
19	Nov 2015	Confirmation of QC rebate and sign posted	VT		Complete
20	Nov 2015	Credit to be applied RTD Pathway kit	AC/VT		Complete
21	Nov 2015	Upgrade of RTD software required	AC		Complete
22	Nov 2015	Review of KPI attributed to SRU	GB/NH		Complete
23	Nov 2015	CCN for addition of archiving racks to contract	LH		Complete
24	Nov 2015	CCN for addition of A/C unit to contract	LH		Complete
25	Feb 2016	PoC Module quote required from Clinysis	GH		Complete
26	Feb 2016	List of additional assays and equipment for novation	SM		Complete
27	Feb 2016	BD novation	DG/SM		Complete
28	Feb 2016	Forecast docs to returned asap	All		Complete
29	Feb 2016	Confirm fluid packs credited	LH		Complete
30	Feb 2016	Hep C activity figures to be confirmed	SM		Complete
31	Feb 2016	G8 B Thal figures – confirm credit applied for validation work	LH		Complete
32	Feb 2016	Quantalite usage more than forecast, Check activity and stock held	SM		Complete
33	Feb 2016	KPI data stated 'significant time spent contacting Fife' to be investigated	LH		Complete
34	Feb 2016	Pro lab or Fluid X as a solution for archiving	LH/SM		Complete
35	Feb 2016	Serology lab re organizing costs from enabling fund approx. £1000	SM		Complete
36	Feb 2016	RTD software issues – request to revert to original version	AC/AM		Complete
37	Feb 2016	Sebia interface – work still outstanding (Lisa)	LH		Complete
38	Feb 2016	Confirm training and development costs of £6445.70 have been invoiced	MG		Complete
39	Feb 2016	cIMS and Optimall refresher training requested	LH		Complete
40	Feb 2016	Roche event upon conclusion of 'Track 2 install'	MP		Complete
41	June 2016	CCN for change of D Bil supplier – no additional cost to NHS Fife	LH	Q1 Review	Complete
42	June 2016	Supply Novation template re- bioMerieux addition	LH	Q1 Review	Complete

Number	Date	Action	Owner	Due Date	Status
43	June 2016	Further review of proposed unitary charge required by NHS Fife	KC/DG	Q1 Review	Complete
44	June 2016	Noted increased spend on BG PW to confirm with Heqther	PW	Q1 Review	Complete
45	June 2016	Further breakdown of Sysmex spend requested	VT	Q1 Review	Complete
46	June 2016	CCN required for additional Launch resp kit requirement	LH	Q1 Review	Complete
47	June 2016	Confim B Thal payments corrected	LH/VT	Q1 Review	Complete
48	June 2016	Outstanding Sysmex credit by end of July	LH	Q1 Review	Complete
49	June 2016	Remove Vit D from schedule	MP	Q1 Review	Complete
50	June 2016	CCN required for Prolab archiving racks	LH	Q1 Review	Complete
51	June 2016	RTD software bug/patch fix not available –official response required	AC	Q1 Review	Complete
52	June 2016	Clarification required on different interpretations of slide drawer colour change	AC	Q1 Review	Complete
53	June 2016	IHC product delivery timeline slipping if not urgent	AC	Q1 Review	Complete
54	June 2016	Paul Skingley to visit in Aug	PS	Q1 Review	Complete
55	June 2016	Completion of Sebia on going interface issues	LS	Q1 Review	Complete
56	Oct 2016	Email LH Poct Clinysis quote	SM	Q2 Review	Complete
57	Oct 2016	BioMeriuex Pricing	LH	Q2 Review	Complete
58	Oct 2016	Re Send June statement	LH	Q2 Review	Complete
59	Oct 2016	Discuss BG kit sizes and worrkload	MP/JM	Q2 Review	Complete
60	Oct 2016	Breakdown of Sysmex G8 and GX costs	LH/VT	Q2 Review	Complete
61	Oct 2016	Ken to email Lesley details of G8 tech issues	KC	Q2 Review	Complete
62	Oct 2016	Update required of coag connectivity	MP	Q2 Review	Complete
63	Oct 2016	Micro air con LH to advise if enabling fund can be used	LH	Q2 Review	Complete
64	Oct 2016	cITM server issues and date for upgrade required, update on 'live feed'	MP	Q2 Review	Complete
65	Oct 2016	Request replacement FOC Optiview kit	SC	Q2 Review	Complete
66	Oct 2016	Tosoh - Review last year's actuals with forecast	LH/KC	Q2 Review	Complete
67	Oct 2016	Report unacceptable helpdesk response time	LH	Q2 Review	Complete
68	Oct 2016	P Forster to review on line training modules and advise MP	PF/MP	Q2 Review	Complete
69	Nov 2016	Fife Finance would like 'true overspend' highlighted minus BioMerieux equipment costs,	VT	Q3 Review	Complete
70	Nov 2016	A/C acceptance form to be signed	LH	Q3 Review	Complete
71	Nov 2016	Request raise NRC relating to poor engineering support	MP	Q3 Review	Complete
72	Nov 2016	Note poor Sysmex response times	LH	Q3 Review	Complete
73	Nov 2016	cITM upgrade on going monitoring for stability	SM	Q3 Review	Complete
74	Nov 2016	Optiomall system crashes if greater an 16 items on order. Who to report to? – see item 89	SM/LH	Q3 Review	Complete
75	Nov 2016	Micro would like 3rd party items on cIMS	LH	Q3 Review	Complete
76	Nov 2016	Consultants need more training awareness to cITm serology, reconfiguration	MP	Q3 Review	Complete
77	Nov 2016	Official response re on going software bug (batch loading)	AC	Q3 Review	Complete
78	Nov 2016	CNN for antibodies not on contract	AM/LH	Q3 Review	Complete
79	Nov 2016	Difficulty getting Thermo parts	LH	Q3 Review	Complete
80	Nov 2016	4 weekly orders (CS) rather than monthly next year	MP	Q3 Review	Complete
81	Nov 2016	Bar codes on Gentamicin not reading correctly Mike Anderson to discuss with Dave McLean.	MA	Q3 Review	Complete
82	Nov 2016	Spent £3k on training invoices to Roche outstanding	DG	Q3 Review	Complete
83	Feb 2017	More contacted requested with Roche PoC team	JM	Q4 Review	Complete
84	Feb 2017	Clinysis quote for software only hardware needs to be sourced	SM	Q4 Review	Complete
85	Feb 2017	Chase up PO for Biomerieux interface	LH/SM	Q4 Review	Complete
86	Feb 2017	Send finance info FAO Jacqueline Adamson	LH/VT	Q4 Review	Complete

Number	Date	Action	Owner	Due Date	Status
87	Feb 2017	Telephone support communication still not good	MP/LH	Q4 Review	Complete
88	Feb 2017	Mike Anderson to contact re clTM stability	MA	Q4 Review	Complete
89	Feb 2017	Optimall ordering issues case to be raised	SM	Q4 Review	Complete
90	Feb 2017	clMs part of contract for North Lab (Micro + Histo)	GC	Q4 Review	Complete
91	Feb 2017	Migration for v 2 track Microbiology code applied to samples, is it through lab center or clTm, require training on seriology	MP/GC	Q4 Review	Complete
92	Feb 2017	Invoice for training fund, request to get in for March	JA	Q4 Review	Complete
93	Feb 2017	Check if 'Lab enabling fund' can be listed in statement	LH	Q4 Review	Complete
94	Feb 2017	Supply details of engineering coverage	MP	Q4 Review	Complete
95	Feb 2017	Reviewing Molecular platform, wish to know workflow potential for future	GC	Q4 Review	Complete
96	Feb 2017	Trial site for P504s – reagent is stuck with customs update required	AC	Q4 Review	Complete
97	May 2017	Future Micro platform options discussed. Possible financial implications for current contracts	SM	Q1 Review	Complete
98	May 2017	Was impact from Dialysis, factored into BG 2017-18 forecast	JM	Q1 Review	Complete
99	May 2017	Cfas credit agreed MP to confirm.	MP	Q1 Review	Complete
100	May 2017	Thermo – lack of application support – GCMS. LH to investigate	LH	Q1 Review	Complete
101	May 2017	UPS's – not fit for purpose, is there a longer life battery pack available? Should they be maintained? MP to clarify.	MP	Q1 Review	Complete
102	May 2017	Sysmex split deliveries ordering LH to investigate.	LH	Q1 Review	Complete
103	May 2017	Bio-Rad controls updated list and class	LH	Q1 Review	Complete
104	Aug 2017	Engineering Support - feedback to relevant personnel in Roche request Tech Service visit	LH	Q2 Review	Complete
105	Aug 2017	Details of the support call taking over an hour	KC	Q2 Review	Complete
106	Aug 2017	PoC Server - Timeframe for server to be purchased	LH	Q2 Review	Complete
107	Aug 2017	CellPath/BT offsite storage - costs	LH	Q2 Review	Complete
108	Aug 2017	To email D Galloway with figures relating to the increase in Gentamicin testing	NG	Q2 Review	Complete
109	Aug 2017	To email L Hawthorn with a copy of previous email sent regarding HbA1c	KC	Q2 Review	Complete
110	Aug 2017	CellPath Blue kit - provide LH with Qty for forecast to be done	DS	Q2 Review	Complete
111	Aug 2017	Fault Response - ▪ To email LH details of reduced capacity due to fault with analyser	DS	Q2 Review	Complete
112	Aug 2017	Thermo - request application specific training	LH	Q2 Review	Complete
113	Aug 2017	First Media - contact D Galloway with final dates and update re brochure	MP	Q2 Review	Complete
114	Aug 2017	Sebia Driver - To obtain a progress report and advise N Greig	LH	Q2 Review	Complete
115	Nov 2017	Cell Path - To speak to Jason re problem with carousel, leaving behind redundant parts and estates protocol	BE	Q3 Review	Complete
116	Nov 2017	Arrange £75K credit	LH	Q3 Review	Complete
117	Nov 2017	G8 & Betta Thals -To check emails and advise L Hawthorn	KC	Q3 Review	Complete
118	Nov 2017	Training Fund To speak to Ann	RL	Q3 Review	Complete
119	Nov 2017	clMS Training To check contract with Microbiology to establish if clMS training was included	MP	Q3 Review	Complete
120	Nov 2017	Cell path – Immuno Chem Air conditioning To obtain a quote for the air conditioning	DS	Q3 Review	Complete
121	Nov 2017	First Sight Media To confirm date when First Sight Media will visit North Lab	MP	Q3 Review	Complete
122	Nov 2017	Endowment Monies for Vetting Queue To contact Ian regarding the approval process	DG	Q3 Review	Complete
123	Feb 2018	Delays to Sysmex via 3rd party helpdesk	LH	Q4 Review	Complete

Number	Date	Action	Owner	Due Date	Status
124	Feb 2018	Cellpath support issue as no weekend cover for UPS breakdown	AC	Q4 Review	Closed
125	Feb 2018	Following multiple occurrence of the same issue on pre analytics MP to advise re internal escalation process	MP	Q4 Review	Complete
126	Feb 2018	Verification of final BThal & HbA1c for credit purposes	KC/LH	Q4 Review	Complete
127	Feb 2018	Quote from Biomerieux for additional prep stations for CCN	SM	Q4 Review	Complete
128	Feb 2018	Sebia driver official update required	LH	Q4 Review	Complete
129	Feb 2018	First Sight Media Booklet to be circulated for review	MP	Q4 Review	Complete
130	Feb 2018	Feedback dates on the sign off dates for Vitek and Maldi to be forwarded to LH	SM	Q4 Review	Complete
131	Feb 2018	Cell-Path - Feed back information to be given regarding delay with action notices	LH/AC	Q4 Review	Complete
132	Feb 2018	Novation of Calprotectin information to be sent	NG	Q4 Review	Complete
133	Feb 2018	Liam (Sysmex) to be emailed re Coag final validation sign off	KC	Q4 Review	Complete
134	Feb 2018	Request revised pricing of Launch kits based on increased usage.	LH	Q4 Review	Closed
135	Feb 2018	Glucose mini tender To be included in MSC when signed off	KC	Q4 Review	Complete
136	Feb 2018	Site visit dates to be considered	MP	Q4 Review	Complete
137	Feb 2018	Thermo contract Performance to be monitored with a view to switching supplier	NG/KC	Q4 Review	Complete
138	May 2018	KC to forward the final HbA1c workload figures.	KC	Q1 Review	Complete
139	May 2018	CCN for BioMerieux software SM to forward to LH	SM/LH	Q1 Review	Closed
140	May 2018	BD Novation process outstanding	LH	Q1 Review	Complete
141	May 2018	Confirm BioMerieux on KPI list	LH	Q1 Review	Complete
142	May 2018	Contact Marie Green re addition of 3 rd party stock on cIMS	LH	Q1 Review	Complete
143	May 2018	Contact DiaSorin re increased 'add on rate'	LH	Q1 Review	Complete
144	May 2018	Quote for A/C unit	LH	Q1 Review	Complete
145	May 2018	Issue with the pC02 batches of sensors that are not performing	LM	Q1 Review	Complete
146	May 2018	Roche to provide details of options to include an additional ISE unit with c502 module	MP	Q1 Review	Complete
147	Aug 2018	Provide Derek Selbie with AirCo contact details	LH	Q2 Review	Complete
148	Aug 2018	D. Galloway requested changes to format of First Sight Media timings and content	LH	Q2 Review	Complete
149	Aug 2018	'Port' for cIMS connection before roll out and training	SM/MP	Q2 Review	Closed
150	Aug 2018	Increased numbers spend on TTGA – query price review	LH	Q2 Review	Closed
151	Aug 2018	RTD engineering waste to be uplifted	AC	Q2 Review	Complete
152	Aug 2018	Updated UC forecast to include CCN 33 and Launch FTD Resp assay	LH	Q2 Review	Complete
153	Aug 2018 Aug 2018	Blood Sciences to discontinue Rheumatoid Factor. SA to be canceled	NG/KC	Q2 Review	Complete
154	Aug 2018	Training fund info to be supplied to allow payment of invoice	DG	Q2 Review	Complete
155	Aug 2018	Familiarisation BNP kits to be arranged	MP	Q2 Review	Complete
156	Aug 2018	Discussion re on going requirement for piccolo and confirmation of Roche decontamination protocol	MP	Q2 Review	Complete
157	Nov 2018	Cell Path – Immuno Chem air conditioning obtain quotes that also includes the crane hire.	DS	Q3 Review	Complete
158	Nov 2018	Further training costs follow up with Ann and forward other training costs to L Hawthorn	DG	Q3 Review	Complete
159	Nov 2018	Werfin Termination of Lease CCN and PO to be raised	LH	Q3 Review	Complete
160	Nov 2018	To obtain a more robust decontamination protocol	MP	Q3 Review	Complete
161	Nov 2018	Investigate HSV increased usage	SM	Q3 Review	Complete

Number	Date	Action	Owner	Due Date	Status
162	Nov 2018	Investigate RGPCR kit increased usage	SM	Q3 Review	Complete
163	Nov 2018	Investigate lack of BioMerieux forecast	LH	Q3 Review	Complete
164	Nov 2018	Establish what Biomerieux AST643 replaced.	SM	Q3 Review	Complete
165	Nov 2018	Follow up on credit note	LH	Q3 Review	Complete
166	Nov 2018	Further training invoice	DG/LH	Q3 Review	Complete
167	Nov 2018	Forward details of blood glucose mini tender	HH	Q3 Review	Complete
168	Feb 2019	CCN – Histo air conditioning	LH	Q1 Review	Complete
169	Feb 2019	Forward Haematology/Coag Delivery Schedule FAO Sarah Dack	LH	Q4 Review	Complete
170	Feb 2019	Sample Check Module - raise with Global	LH/MP	Q4 Review	Complete
171	Feb 2019	Glucose Connectivity Meters - speak to Lee McMullen regarding Clinisys asking for monies for additional licenses following the renewal of contract with Roche for additional 80 meters	L McM	Q4 Review	Complete
172	Feb 2019	Disposal of HTZ - check who will dispose of the HTZ	LH	Q4 Review	Complete
173	Feb 2019	NHS England Brexit Document - forward to the managers	MP	Q4 Review	Complete
174	Feb 2019	Finance - Follow up on credit note	LH	Q4 Review	Complete
175	Feb 2019	Training Fund - To check invoices for Thermo Training and advise L Hawthorn if there is an invoice for £1500	AB	Q4 Review	Complete
176	Feb 2019	Dialog - confirm if photos can be uploaded onto system.	MP	Q4 Review	Complete
177	Feb 2019	RGPCR Investigate	SM	Q4 Review	Closed
178	Feb 2019	IFRS1- Confirm to D Galloway with a statement (if required/requested) advising that the information is not required	LH/DG	Q4 Review	Complete
179	May 2019	Can engineering stock be held on-site re belts	MP	Q1 Review	Complete
180	May 2019	Updated quotation and CCN required NTproBNP	MP	Q1 Review	Complete
181	May 2019	Piano Software find out if a second application is possible	KC	Q1 Review	Closed
182	May 2019	Raise a PO for the Outstanding £77K	DG	Q1 Review	Closed
183	May 2019	Vitek N382 Investigate Spend	SMcG	Q1 Review	Complete
184	May 2019	PO for £5,731 to be provided and invoice to be raised	AB	Q1 Review	Complete
185	May 2019	Provide hard copies of NHS Fife brochure for site visitors	MP	Q1 Review	Complete
186	May 2019	Send electronic copy of brochure to all staff	DG	Q1 Review	Complete
187	May 2019	Check that asset register is up to date on both laboratory sites	MP	Q1 Review	Complete
188	May 2019	Take advice re cobas Infinity from procurement	KC	Q1 Review	Complete
189	May 2019	Launch pricing, to discuss with C Ferguson for Clinical Decision	SM	Q1 Review	Complete
190	May 2019	Update correct contract year in next report	MP	Q1 Review	Complete
191	May 2019	Provide 2019/2020 MLS Meeting Dates	MP	Q1 Review	Complete
192	Aug 2019	Circulate Roche Brexit Letter	MP	Q2 Review	Complete
193	Aug 2019	To order any extra stock by mid-September (Brexit)	KC,DS,SM	Q2 Review	Complete
194	Aug 2019	Request help setting up cIMs, email MP with NHS IT contact	SM	Q2 Review	Complete
195	Aug 2019	Change from Thermo to E&O – to advise MP of products	SM	Q2 Review	Complete
196	Aug 2019	Drain issue Cell Path – forward email history to follow up	DS	Q2 Review	Complete
197	Aug 2019	Veolia give deadline for decontamination work to be carried out	MP	Q2 Review	Complete
198	Aug 2019	Veolia obtain quote for 2nd tank for Haem	MP	Q2 Review	Complete
199	Aug 2019	Obtain copy of cITm upgrade plan from Mike Anderson	KC, SM	Q2 Review	Complete
200	Aug 2019	Establish if 2nd Piano is feasible due to costs	KC	Q2 Review	Closed
201	Aug 2019	Roche Dialog, forward information to DS & SM	MP	Q2 Review	Complete
202	Aug 2019	Provide a formula for calculating monies for KPIs	AG	Q2 Review	Complete
203	Aug 2019	Advise J Adamson estimation of flu cases this year	SM	Q2 Review	Complete
204	Feb 2020	Training onsite cITm North Lab Marie Green	MG	Q3 Review	Complete
205	Feb 2020	List of reagents required from E&O to be sent to MP	SM	Q3 Review	Complete
206	Feb 2020	Sysmex tidy up after install, quote from Tracey Good	MP/KC	Q3 Review	Complete
207	Feb 2020	Consider 3rd BMK Ultra	CR/DS	Q3 Review	Complete
208	Feb 2020	G8 variant injections 5% increase year on year AG to investigate	AG/KC	Q3 Review	Ongoing
209	May 2020	Thermo Oxoid refund	MP	Q1 Review	Complete
210	Aug 2020	Optimal Insight Meeting Oct send invite to all Managers	MP	Q2 Review	Complete
211	Aug 2020	Review Blood Glucose spend	AG/JA	Q2 Review	Complete
212	Aug 2020	Set up cLiat meeting end Sept	MP/GC	Q2 Review	Complete

Number	Date	Action	Owner	Due Date	Status
213	Aug 2020	Sysmex drain lead needing fixed	MP	Q2 Review	Complete
214	Aug 2020	eHealth Form needs completed by NHS Fife before clMs project	MP/KC	Q2 Review	Complete
215	Dec 2020	Software update Coag	KH/KC	Q2 Review	Closed
216	Dec 2020	Resend CCN Ultra with annual speand	DG/MP	Q2 Review	Complete
217	Dec 2020	IT 1000 issues with backlog results, monitor progress	HH/LM	Q2 Review	Complete
218	Dec 2020	Qiagen supplies fragile, monitor	SM/MP	Q2 Review	Complete
219	Dec 2020	Allocation of LIAT tests, concern around timelines monitor	GC/SM	Q2 Review	Complete
220	Dec 2020	Set up meeting re NHS Fife Microbiology Contract	MP/SM	Q2 Review	Complete
221	Dec 2020	Refund from NDC Supply Chain disruption	MP	Q2 Review	Complete
222	Feb 2021	Blood gas analyser to be novated into MLS contract	KC	Q1 Review	Complete
223	Feb 2021	Cryostats to be added to MLS contract	DS	Q1 Review	Complete
224	Feb 2021	E&O CCN to be generated	EW	Q1 Review	Complete
225	Feb 2021	Balance of Unitary Charge up to end of Feb to be sent	MP	Q1 Review	Complete
226	Feb 2021	Blood gas underspend to be investigated	HH/LM	Q1 Review	Complete
227	Feb 2021	Cobas 8100 overspend to be investigated	SH	Q1 Review	Complete
228	Feb 2021	Roche CT/NG to be removed from forecast	SH	Q1 Review	Complete
229	Feb 2021	Gap analysis for current contract vs new contract	DG/KC/SM/DS/MP/MA	Q2 Review	Complete
230	May 2021	Contact details to be checked	EW	Q2 Review	Complete
231	May 2021	Blood gas analyser to be novated into contract.	KC/MP	Q2 Review	Complete
232	May 2021	SM to advise if kit requires to be novated into contract	SM	Q2 Review	Complete
233	May 2021	LM to find if driver for Abbott ID can go through IT1000	LM	Q2 Review	Complete
234	May 2021	CCN for Qiagen	EW	Q2 Review	Closed
235	May 2021	Workload statistics for next contract to be obtained	DS	Q2 Review	Complete
236	May 2021	CS-5100 connection follow up with Mike Anderson	MP	Q2 Review	Complete
237	May 2021	SM to look at Unitary Charge forecast for microbiology	SM	Q2 Review	Complete
238	May 2021	8100 Aliquoter Module budget to be amended	SH	Q2 Review	Complete
239	May 2021	CT/NG to be removed from finance report	SH	Q2 Review	Complete
240	May 2021	BioMerieux connection awaiting PO	EW/MP	Q2 Review	Complete
241	May 2021	Look at QBR and suggest improvements	MP/KC	Q2 Review	Complete
242	Aug 2021	Inventory Management escalation for non-MLS items	MP	Q3 Review	Complete
243	Aug 2021	SM requested replacement LIATs for returned kit. GC to investigate.	GC	Q3 Review	Complete
244	Aug 2021	CR to update on Haematoxylin supply issue	CR	Q3 Review	Complete
245	Aug 2021	Sysmex coag back up server to be finalized. MP to push	MP	Q3 Review	Closed
246	Aug 2021	HbA1c reruns to be established to remove from count	SD	Q3 Review	Complete
247	Aug 2021	Monthly finance meetings to be set up	EW	Q3 Review	Complete
248	Aug 2021	Investigate budget to ensure glucose spend is not tied in with POC	SH	Q3 Review	Complete
249	Aug 2021	FTD Respiratory Pathogens from Launch to be removed from budget	SH	Q3 Review	Complete
250	Aug 2021	Spend for training fund to be sent to Roche	KC	Q3 Review	Complete
251	Nov 2021	MA to send proposals of alternative inventory management suppliers	MA	Q4 Review	Ongoing
252	Nov 2021	Ummonium delivery delays: CR to discuss with DS	CR	Q4 Review	Complete
253	Nov 2021	Update on Haemoglobinopathies mini-tender	MA	Q4 Review	Complete
254	Nov 2021	SH to discuss Q2 PO with JA. KC to be copied.	SH/JA	Q4 Review	Complete
255	Nov 2021	Quote to be obtained for work on drains, to come from enabling fund	KC	Q4 Review	Complete
256	Feb 2022	EPU server for coag to be escalated with Sysmex	MP	Q1 Review	Complete
257	Feb 2022	Prep Kits to be made FOC	CR	Q1 Review	Complete
258	Feb 2022	Ummonium stock outage update required	CR	Q1 Review	Complete
259	Feb 2022	Engineering response delays to be discussed at meetings	MP	Q1 Review	Complete
260	Feb 2022	Formal response to clTm server upgrade complaint required	MP	Q1 Review	Complete
261	Feb 2022	Additional IBMS related costs to go through training fund	KC	Q1 Review	Ongoing
262	Feb 2022	Drain invoice to be put through enabling fund	MP	Q1 Review	Ongoing
263	Feb 2022	No KPI related credits showing on January Financial Statement	SH	Q1 Review	Complete
264	Feb 2022	Meeting required to escalate Fife installation timelines	MP	Q1 Review	Complete

Appendix 2 – Contract Change Notices

Reference Number	Date Raised	Title Of The Change	Impact Assessment Undertaken By	Impact Assessment Undertaken On	Accepted / Rejected	Accepted / Rejected By	Costs / Savings
CCN 001	Aug 2014	Implementation Plan	Raife Barton	Aug 2014	Accepted	Chris Bowring	Nil
CCN 002	Aug 2014	Change of Supplier	Olga Greenan	Sept 2014	Accepted	Olga Greenan	£1,100
CCN 003	Aug 2014	GBM Assay	Stephen McGlashan	Sept 2014	Accepted	Olga Greenan	£1,532
CCN 004	Nov 2014	IL-Name Change	Lesley Hawthorn	Nov 2014	Accepted	Olga Greenan	Nil
CCN 005	Feb 2015	Roche CTNG Testing	Alyssun Grant	Feb 2015	Accepted	Chris Bowring	£79,843
CCN 006	Feb 2015	Sysmex BioPhen	Ken Campbell	Mar 2015	Accepted	Olga Greenan	£408
CCN 007	Jan 2015	Change of QC Supplier	Olga Greenan	Mar 2015	Accepted	Olga Greenan	£9,860
CCN 008	Mar 2015	Oxoid Media	Olga Greenan	Apr 2015	Accepted	Chris Bowring	£89,145
CCN 009	Jan 2015	Thermo Slides	Olga Greenan	Mar 2015	Accepted	Olga Greenan	£2,226
CCN 010	Jan 2015	Werfen camera	Olga Greenan	Mar 2015	Accepted	Olga Greenan	£2,420
CCN 011	Apr 2015	Lab enabling fund	Olga Greenan	July 2015	Accepted	Olga Greenan	£12,000
CCN 012	May 2015	Thermo Consumables	Olga Greenan	May 2015	Accepted	Olga Greenan	£3,171
CCN 013	Apr 2015	RTD BenchMark Ultra's	Olga Greenan	June 2015	Accepted	Chris Bowring	£86,377
CCN 014	May 2015	Sysmex QC Material	Ken Campbell	July 2015	Accepted	Olga Greenan	£5,057
CCN 015	May 2015	Methadone Metabolites Costs	Ken campbell	July 2015	Accepted	Olga Greenan	Nil
CCN 016	Jun 2015	Werfen Anti tTg	Philip Wenham	July 2015	Accepted	Olga Greenan	£7,810
CCN 017	Jun 2015	Creatinine price Amendment	Ken Campbell	July 2015	Accepted	Olga Greenan	Nil
CCN 018	Jun 2015	GCMS Consumables	Olga Greenan	July 2015	Accepted	Olga Greenan	£1,047
CCN 019	Jun 2015	DiaSorin QC	Olga Greenan	Oct 2015	Accepted	Olga Greenan	-£3,920
CCN 020	Jun 2015	Nikon Microscopes	Olga Greenan	July 2015	Accepted	Olga Greenan	£4,175
CCN 021	Sep 2015	Thermo Oxoid Culti Loops	Olga Greenan	Oct 2015	Accepted	Olga Greenan	£3208.26
CCN 022	Sep 2015	Launch DS2 Novation	Olga Greenan	Oct 2015	Accepted	Chris Bowring	£111,053
CCN 023	Oct 2015	BioMerieux Maldi	Olga Greenan	Jan 2016	Accepted	Chris Bowring	£107,858.21
CCN 024	Apr 2016	Additional Sysmex assays	Lesley Hawthorn	Apr 2016	Accepted	Donna Galloway	£3,000.60
CCN 025	July 2016	Launch Assays - Increased Workload	Lesley Hawthorn	July 2016	Accepted	Donna Galloway	£38,898.20
CCN 026	July 2016	ProLab	Lesley Hawthorn	July 2016	Accepted	Donna Galloway	£2,352.00
CCN 027	July 2016	Direct Bilirubin – Change of supplier	Lesley Hawthorn	July 2016	Accepted	Donna Galloway	Nil
CCN 028	July 2016	Diasorin TTG	Lesley Hawthorn	July 2016	Accepted	Donna Galloway	£18,310.00
CCN 029	Oct 2016	Air conditioning	Lesley Hawthorn	Oct 2016	Accepted	Donna Galloway	Nil- enabling fund
CCN 030	Oct 2016	Building Works	Lesley Hawthorn	Oct 2016	Accepted	Donna Galloway	Nil – enabling fund
CCN 031	Apr 2017	Additional Werfen Consumables	Lesley Hawthorn	May 2017	Accepted	Donna Galloway	£108

Reference Number	Date Raised	Title Of The Change	Impact Assessment Undertaken By	Impact Assessment Undertaken On	Accepted / Rejected	Accepted / Rejected By	Costs / Savings
CCN 032	Aug 2017	Panasonic Refrigeration	Lesley Hawthorn	Aug 2018	Accepted	Donna Galloway	£1,300.78
CCN 033	Sep 2017	Novation of Qiagen	Lesley Hawthorn	Sep 2017	Accepted	Donna Galloway	£165,004.41
CCN 034	Dec 2017	Micro additions Multiple	Lesley Hawthorn	Dec 2017	Accepted	Donna Galloway	£8,203.23
CCN 035	Dec 2017	Product change notification	Rob Saunders	Dec 2017	Accepted	Donna Galloway	£120.59
CCN 036	Dec 2017	Supplier Change of Business name	Rob Saunders	Dec 2017	Accepted	Donna Galloway	Nil
CCN 037	Dec 2017	Additional Thermo Scientific consumables	Lesley Hawthorn	Dec 2017	Accepted	Donna Galloway	£83.80
CCN 038	Mar 2018	Addition of CLS ACE consumables	Lesley Hawthorn	Mar 2018	Accepted	Donna Galloway	£5,896.00
CCN 039	Mar 2018	Histo Reagents (multiple suppliers)	Lesley Hawthorn	Mar 2018	Accepted	Donna Galloway	£19,455.62
CCN 040	Apr 2018	Roche Addition of Alpha 1	Lesley Hawthorn	Apr 2018	Accepted	Donna Galloway	£1,270.88
CCN 041	Apr 2018	Additional Sysmex Consumables	Lesley Hawthorn	Apr 2018	Accepted	Donna Galloway	£429.10
CCN 042	July 2018	Veolia Water Dispense Gun	Lesley Hawthorn	July 2018	Accepted	Donna Galloway	£495.50
CCN 043	July 2018	Werfen Application Support	Lesley Hawthorn	July 2018	Accepted	Donna Galloway	£600.00
CCN 044	July 2018	Diasorin Relocation	Lesley Hawthorn	July 2018	Accepted	Donna Galloway	£0.00
CCN 045	July 2018	BD Novation	Lesley Hawthorn	July 2018	Accepted	Donna Galloway	£49,786.60
CCN 046	Nov 2018	Werfen HTZ320	Lesley Hawthorn	Nov 2018	Accepted	Donna Galloway	£0.00
CCN 047	Nov 2018	Addition of Technopath QC	Lesley Hawthorn	Nov 2018	Accepted	Donna Galloway	£2,379.30
CCN 048	Dec 2018	Addition of cobas LIAT	Lesley Hawthorn	Dec 2018	Accepted	Donna Galloway	£40,600.00
CCN 049	Dec 2018	Addition of consumables Qiagen and Pro Lab	Lesley Hawthorn	Dec 2018	Accepted	Donna Galloway	£1,336.85
CCN 050	Apr 2019	A/C Unit for Histo Pathology	Lesley Hawthorn	May 2019	Accepted	Donna Galloway	£2,045.29

CCN No.	Date Requested	CCN Title	Accepted / Rejected	Date Issued	CCN Signature Date	Total Cost p.a	VAT Savings
CCN 051	26/06/2019	Addition of VTRust Ketone Meter	Accepted	26/06/2019	03/07/2019	£57,288.00	£11,457.60
CCN 052	18/07/2019	Brahms PCT	Accepted	22/07/2019	23/07/2019	£18,354.60	£3,670.92
CCN 054	22/11/2019	Blood Bank Fridge	Accepted	02/12/2019	02/12/2019	£3,517.27	£703.45
CCN 053	26/11/2019	Additional cobas LIAT	Accepted	26/11/2019	02/12/2019	£29,868.62	£5,973.72
CCN 055	28/04/2020	Addition of Factor Xa Cals and Controls	Accepted	29/04/2020	30/04/2020	£0.00	£0.00
CCN 056	18/05/2020	NTproBNP	Accepted	26/05/2020	02/06/2020	£8,994.58	£1,798.92
CCN 57	14/09/2020	Addition of Chromsystems and reagents to managed service.	Rejected			£0.00	£0.00

CCN 058	19/11/2020	Fife Roche Ventana lease deal 3 1 1 years with cost per test reportable.	Rejected	24/11/2020		£55,383.13	£11,076.63
~~CCN 059~~	~~23/11/2020~~	~~Quiagen addition - QIAstat-Dx Gastrointestinal Panel~~	~~Cancelled~~	-	-	~~£9,921.60~~	~~£1,984.32~~
CCN 058	03/12/2020	Fife Roche Ventana lease deal 3 1 1 years Amended CCN 58	Accepted	04/12/2020	04/12/2020	£19,653.50	£3,930.70
CCN 60	04/03/2021	Addition of E&O Reagents	Accepted	05/05/2021	11/05/2021	-£7,783.00	-£1,556.60
~~CCN 61~~	~~30/03/2021~~	~~Addition of Qiagen Instrumentation, Service~~	~~Cancelled~~	-	-	~~£0.00~~	~~£0.00~~
CCN62	22/04/2021	Transfer of Roche SARS-Cov-2 Products into Main Contract	Accepted	06/05/2021	13/05/2021	£0.00	£0.00
CCN 63	24/05/2021	Addition of Roche Kits for Pre-eclampsia Testing	Accepted	25/05/2021	25/05/2021	£42,882.02	£8,576.40
CCN 064	18/06/2021	Novation of Cobas B123 and Addition of Service Contract	Accepted	21/06/2021	21/06/2021	£2,500.00	£500.00

Appendix 3 –KPI's

Service Levels and Service Points

System Downtime and Complete System Downtime

	Band	Permitted System Downtime expressed in hours per Quarterly Period	Service Failure Points per Component for each relevant hour above the Permitted System Downtime
System Downtime – measured per System during Service Hours	Band A	44	5
	Band B	66	3
	Band C	88	3
Complete System Down Time measured during Service Hours Unapproved Downtime resulting in Reportable Results not being reported from the relevant System in respect of Urgent Critical Tests	Not applicable – applies in respect of each every System	2	15

System Downtime is the sum of the Unapproved Downtime for all Component of the relevant System.

Test Turnaround Time

	Service Level	Service Points
Test Turnaround Time. Reportable Results must be available for Urgent Critical Tests in under 1 hour on 90% of occasions measured over a Quarterly Period	90% measured as a percentage of the Urgent Critical Tests.	ten (10) Service Failure Points per each zero point one percent (0.1%) below Service Level

Service Levels and Service Failure Points

Response Time and Engineer Response Time

	Band	Hours	Service Points for each relevant hour above Service Level
Engineer Response Time (Core hours) Note – Service Levels to apply in respect of Interim Components	Band A	6	8
	Band B	By 6pm on the next Working Day	8
	Band C	By 6pm on the next Working Day	8

Band A Systems	Site	Systems
A1	South Laboratory	Pre/Post analytics, Clinical Biochemistry, WPDM,
A2	South Laboratory	FBC, Coagulation
A3	Queen Margaret Hospital	Haematology Clinic FBC
A4	South Laboratory	Immunoassay
A5	North and South Laboratory and Victoria Hospital	SMS (Middleware solutions)
Band B systems	**Site**	**Systems**
B1	Victoria Hospital wards and South Laboratory	Blood Gas
B2	South Laboratory	Serology
B3	South Laboratory	Immunology
B4	South Laboratory and Diabetes Clinics at Victoria Hospital and Queen Margaret Hospital	HbA1C
B5	South Laboratory	Haematology, ESR
Band C systems	**Site**	**Systems**
C1	South Laboratory	Electrophoresis, Drugs of abuse confirmations, CSF spectrophotometry, Osmolality
C2	South Laboratory	Haemoglobinopathy screening

ANNEX 4

Illustration of Service Failure Points

Service Failure Points	Service Credits	Service Failure Points	Service Credits	Service Failure Points	Service Credits	Service Failure Points	Service Credits	Service Failure Points	Service Credits
1	£1.00	51	£245.81	101	£639.81	151	£1,123.49	201	£1,676.77
2	£2.64	52	£252.58	102	£648.69	152	£1,133.92	202	£1,688.46
3	£4.66	53	£259.41	103	£657.62	153	£1,144.37	203	£1,700.18
4	£6.96	54	£266.29	104	£666.57	154	£1,154.86	204	£1,711.92
5	£9.52	55	£273.22	105	£675.56	155	£1,165.37	205	£1,723.68
6	£12.29	56	£280.20	106	£684.59	156	£1,175.91	206	£1,735.46
7	£15.25	57	£287.23	107	£693.65	157	£1,186.48	207	£1,747.26
8	£18.38	58	£294.31	108	£702.74	158	£1,197.07	208	£1,759.09
9	£21.67	59	£301.43	109	£711.86	159	£1,207.69	209	£1,770.94
10	£25.12	60	£308.61	110	£721.02	160	£1,218.34	210	£1,782.82
11	£28.70	61	£315.84	111	£730.22	161	£1,229.01	211	£1,794.71
12	£32.42	62	£323.11	112	£739.44	162	£1,239.71	212	£1,806.63
13	£36.27	63	£330.43	113	£748.70	163	£1,250.44	213	£1,818.58
14	£40.23	64	£337.79	114	£758.00	164	£1,261.19	214	£1,830.54
15	£44.31	65	£345.21	115	£767.32	165	£1,271.97	215	£1,842.53
16	£48.50	66	£352.66	116	£776.68	166	£1,282.78	216	£1,854.54
17	£52.80	67	£360.17	117	£786.07	167	£1,293.61	217	£1,866.57
18	£57.20	68	£367.72	118	£795.49	168	£1,304.47	218	£1,878.62
19	£61.70	69	£375.31	119	£804.94	169	£1,315.35	219	£1,890.70
20	£66.29	70	£382.95	120	£814.43	170	£1,326.26	220	£1,902.79
21	£70.98	71	£390.63	121	£823.95	171	£1,337.19	221	£1,914.91
22	£75.75	72	£398.35	122	£833.50	172	£1,348.15	222	£1,927.06
23	£80.62	73	£406.12	123	£843.08	173	£1,359.14	223	£1,939.22
24	£85.56	74	£413.93	124	£852.69	174	£1,370.15	224	£1,951.40
25	£90.60	75	£421.78	125	£862.33	175	£1,381.19	225	£1,963.61
26	£95.71	76	£429.67	126	£872.00	176	£1,392.25	226	£1,975.84
27	£100.90	77	£437.61	127	£881.71	177	£1,403.34	227	£1,988.09
28	£106.17	78	£445.59	128	£891.44	178	£1,414.45	228	£2,000.36
29	£111.52	79	£453.61	129	£901.21	179	£1,425.59	229	£2,012.66
30	£116.94	80	£461.66	130	£911.00	180	£1,436.75	230	£2,024.97
31	£122.44	81	£469.76	131	£920.83	181	£1,447.94	231	£2,037.31
32	£128.00	82	£477.90	132	£930.69	182	£1,459.15	232	£2,049.67
33	£133.63	83	£486.08	133	£940.57	183	£1,470.39	233	£2,062.05
34	£139.34	84	£494.30	134	£950.49	184	£1,481.65	234	£2,074.45
35	£145.11	85	£502.56	135	£960.43	185	£1,492.93	235	£2,086.87
36	£150.95	86	£510.86	136	£970.41	186	£1,504.24	236	£2,099.31
37	£156.85	87	£519.19	137	£980.41	187	£1,515.58	237	£2,111.78
38	£162.82	88	£527.56	138	£990.45	188	£1,526.94	238	£2,124.26
39	£168.85	89	£535.98	139	£1,000.51	189	£1,538.32	239	£2,136.77
40	£174.94	90	£544.43	140	£1,010.60	190	£1,549.73	240	£2,149.29
41	£181.09	91	£552.91	141	£1,020.72	191	£1,561.16	241	£2,161.84
42	£187.30	92	£561.44	142	£1,030.87	192	£1,572.61	242	£2,174.41
43	£193.58	93	£570.00	143	£1,041.05	193	£1,584.09	243	£2,187.00
44	£199.91	94	£578.60	144	£1,051.25	194	£1,595.59	244	£2,199.61
45	£206.30	95	£587.24	145	£1,061.49	195	£1,607.12	245	£2,212.24
46	£212.75	96	£595.91	146	£1,071.75	196	£1,618.67	246	£2,224.89
47	£219.25	97	£604.62	147	£1,082.04	197	£1,630.24	247	£2,237.57
48	£225.81	98	£613.36	148	£1,092.36	198	£1,641.84	248	£2,250.26
49	£232.42	99	£622.14	149	£1,102.71	199	£1,653.46	249	£2,262.97
50	£239.09	100	£630.96	150	£1,113.08	200	£1,665.11	250	£2,275.71

Appendix 4 –Glossary

Fixed Costs	Charges constant for the contract term & not subject to annual indexation. Commonly instrument charges or management fees.
Semi-Fixed Costs	Charges subject to annual indexation as specified in the contract. Commonly instrument maintenance charges.
Variable Costs	Charges associated with reagents & consumables purchases, which can vary in volume and would be subject to annual indexation.
Unitary Charge	Forecast value of the contract year used for billing purposes.
Actual	Spend as charged through the customer statement.
Forecast	Predicted spend as billed.
Variance	The difference between actual & forecast spend.
Projected	Estimated quarterly or year-end spend based on actual spend to date.

NHS Fife MLS meeting 24th Feb 2022 minutes

Attendees:
KC – Kenneth Campbell, DS – Derek Selbie, HH – Heather Holmes, SM – Stephen McGlashan, DM – Dave McLean, LL – Lisa Logan, MP – Maureen Polson, EW – Emma Westwick, LH – Lesley Hawthorn, SH – Shannen Hawkes, LM – Lee McMullen
Apologies: JA – Jacqueline Adamson, GC - Garry Cusack, JR – Jenna Robertson

Topic	Action
Minutes of the previous MLS meeting Agreed as a true representation	
Matters Arising EPU server for coag, back up still not operational. Unimpressed with Sysmex as they originally said there was a risk if this was not carried out and now they can't complete it till June. They also advised incorrectly on the need for eHealth involvement which has contributed to delay. MP to raise this at a higher level with Sysmex. Optimall Inventory Management: Fife team still need an alternative supplier for Inventory Management	MP MA
Team Reports Microbiology No issues with current contract. Items relating to new contract: • SM to find a new Legionella supplier • Support for the ProLab kit is being removed as there is a new product • Ongoing discussions with Launch regarding replacement for DS2 Cellular Pathology Prep kits should be FOC, but they aren't. It has been requested multiple times that this is amended but it hasn't been completed. CR to action. The Ummonium stock outage is still causing issues with contamination. CR to discuss with DS Haematology No update Biochemistry Query regarding service contract for Veolia water systems. MP confirmed this was renewed. It was highlighted that Engineer Response is currently not as good as it has been previously. Can sometimes wait for 2 or 3 days for an engineer visit and be	 CR CR MP

operating in contingency mode for that length of time. MP proposed setting up a meeting with the Engineering Manager and also monthly meetings to highlight issues like this at an earlier stage. cITm server upgrade: Ken is still awaiting formal response to complaint regarding no advance warning of this upgrade. MP to request. There are still issues outstanding since this upgrade: no live view screens, no admin access. There was also an incident where Roche IT stopped and started the server without prior notice. This cannot happen and eHealth will remove remote access if this occurs again. There are some long-standing issues that have remained unresolved for a very long time: • The sample check module is still off-line (since 2018) • Coag connectivity outstanding • CAT colour recognition on 8100 not working • 1 tray in the AOB has movement problems and has had to be put out of action since May 2021	MP
<u>Finance</u> No update, issues dealt with at separate Finance meeting.	
<u>Training Fund</u> Balance remaining: £2,555.83 There may be additional costs relating to IBMS that can be put through. KC to advise	KC
<u>Lab Enabling Fund</u> The drain work that is to be put through this fund was completed. Costs to be obtained from Robin Simpson.	MP
<u>KPI</u> NO KPI related credits were showing on the January statement. SH to check.	SH
<u>Future Service Development</u> QBR survey to be sent after the meeting. DOA: Provision for this may need to be included in the new contract, although there are ongoing discussions regarding whether an in-house service is still required. Pathology: DS approached CR asking if there was a framework to procure Vantage. As this is not available, may need to go out to tender.	
<u>Action Tracker</u>	

245 – close 246 – action to move to MP to ask Mary Jarvie 249 – complete 253 – complete	
<u>AOCB</u> LL: advised that the second NeuMoDx is to be installed in the department LM: requested info on timelines for new blood gas analyser installation, to allocate support required for handover. Timeline is not known yet. Financial Pulse: MP explained that a new Financial Management System will be introduced to replace Financial Pulse. In the meantime, enhanced Excel spreadsheets will be used. SH confirmed that the lab teams can advise on functionality required in the new system. Wishlists: MP prompted the team to complete their transition from Scheduled Agreements to DiaLog Wishlists. It was confirmed that Optimall Orders can still be used for ad-hoc orders. Transition to new contract: MP and LH explained that installation of Roche equipment would not be in 2022. KC expressed his disappointment at this, and explained there was an expectation that Fife implementation would roll on from the Lothian implementation. KC will escalate this with Donna Galloway and Mike Gray and requested MP set up a meeting to discuss.	MP
Next Meeting: Wed 25th May, 10-12md	

Agenda

1. **Minutes of the previous MLS meeting**
2. **Matters Arising**
3. **Team Reports / Operational Issue**
4. **Finance**
5. **Training Fund**
6. **Lab Enabling Fund**
7. **KPI Report**
8. **Training Development**
9. **Future Service Development**
10. **Action Tracker**
11. **A.O.B**

Next Meeting TBC

Appendix 5 – KPI Results

Vendor	KPI Name	Pass Target	Score	Comments
ADVANCED INSTRUMENTS LTD	Complete System Downtime	**100.00%**		Instrument reached end of life 27/10/21.
	Equipment Availability - Band C	**97.00%**		Instrument reached end of life 27/10/21.
	Fault Response - Band C	**100.00%**		Instrument reached end of life 27/10/21.
DIASORIN LTD	Complete System Downtime	**100.00%**	**96.58%**	One repair call in this period
	Equipment Availability - Band B	**97.00%**	**96.58%**	Was not on site by 6pm the next day as parts were required to be ordered and delivery delayed fixing instrument
	Fault Response - Band B	**100.00%**	**0.00%**	Was not on site by 6pm the next day as parts were required to be ordered and delivery delayed fixing instrument
Roche Diagnostics Ltd	System Availability	**97.00%**	**99.11%**	CS Downtime: 1466.5 mins Blood Gas Downtime: 267.18 mins TD Downtime: 4576.5 mins
	Critical System Failure	**98.00%**	**100.00%**	KPI not listed
	Engineering Response Times	**100.00%**	**63.16%**	7 of 19 Failed
	Complete System Downtime CS	**100.00%**	**100.00%**	Downtime 1466.5 minutes
	Complete System Downtime Blood Gas	**100.00%**	**100.00%**	Downtime 267.181818 minutes
	Complete System Downtime TD	**100.00%**	**100.00%**	Downtime 4576.5 minutes
	Complete System Downtime MOL	**100.00%**	**100.00%**	
SEBIA (UK) LTD	Complete System Downtime	**100.00%**	**100.00%**	No urgent test
	Equipment Availability - Band C	**97.00%**	**99.00%**	
	Fault Response - Band C	**100.00%**	**0.00%**	2 calls on a Thursday and engineer on site on Monday. Analyser not down on either occasion and results produced
SYSMEX UK LTD	Complete System Downtime	**100.00%**	**100.00%**	

	Equipment Availability - Band A	**98.00%**	**100.00%**	
	Equipment Availability - Band B	**97.00%**	**100.00%**	
	Fault Response - Band A	**100.00%**	**67.00%**	2 calls failed - FSE availability 9 calls only 2 FSE, & XN9 move only 2 FSE's
	Fault Response - Band B	**100.00%**	**100.00%**	
THERMO ELECTRON MANUFACTURING LTD	Complete System Downtime	**100.00%**	**100.00%**	No interactions
	Equipment Availability - Band C	**97.00%**	**100.00%**	No interactions
	Fault Response - Band C	**100.00%**	**100.00%**	No interactions
WERFEN	Complete System Downtime	**100.00%**	**100.00%**	
	Equipment Availability - Band B	**97.00%**	**100.00%**	
	Fault Response - Band B	**100.00%**	**100.00%**	

RECORD OF GENERAL RISK ASSESSMENT (Based on HSE's Five steps to risk assessment)

Department	*Laboratories*
Service	*Finance*
Version	*1.0*
Manager Responsible	*Donna Galloway*
Risk Assessor(s)	*Jacqueline Adamson, Finance Business Partner, WCCS*

Step 1(a)- Description of Process

A Managed Service Agreement for Laboratory Services exists between NHS Fife and Roche Diagnostics. There is no specific risk recorded on the risk register. This risk assessment seeks to ascertain if there is a financial risk or risk of the laboratory contract not performing and affecting operational service requirements.

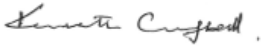
Step 1(b) What are the risks	***Step 2- Who/what might be harmed & how***	***Step 3(a)- Current Controls***	***Step 3(b) Evaluate the risks***
That the contract will not deliver on the original criteria upon which it was agreed	*Laboratory services – Haematology, Blood Transfusion, Microbiology and Cellular Pathology – will not be provided as per the contract agreed. This will impact on patient care.*	*Roche provides a comprehensive quarterly Business Service Report which includes contract scope and additions, unitary charge, contract change notices, statement overview, summary of year to date expenditure against forecast, KPI report and action tracker. There is a quarterly review meeting and a clear process for Dispute Resolution within the contract*	*Remote (1) x Major (4) = 4*
That contract monitoring arrangements will not identify all delivery failures resulting in financial clawbac k.	*Clawback payments may be incorrect which will affect revenue for NHS Fife*	*Service failures are recorded on QPulse and this process is robust and in line with the ISO 15189 accreditation held by all of the laboratories. A breakdown of clawback payments is included in the quarterly business report.*	*Unlikely (2) x Minor (2) = 4*
That variations to the contract are appropriately identified, agreed and costed.	*Inappropriately authorised variations will be in breach of Standing Financial Instructions.*	*A process has been agreed with the Director of Finance around variations to the contract that includes appropriate authorisation in line with SFIs*	*Possible (3) x Moderate (3) = 6*

That the contract will not perform efficiently	*Planned level of service will not be achieved and there may be a financial impact*	*There are processes in place to ensure that the contract is managed efficiently; quarterly review meetings, planned v actual service breakdown and a monthly meeting between the NHS Fife Finance Business Partner and the Roche Management Accountant representative.*	*Possible (3) x Moderate (3) = 9*
That the contract will overperform against yearly forecast.	*Adverse financial impact as costs rise.*	*The quarterly Business Service Report identifies over and underperforming consumables which allows laboratory managers to identify potential rising costs. In addition to this, all areas of the laboratory apply robust demand optimisation principles to testing of patient specimens.*	*Possible (3) x Minor (2) = 6*

Severity / ***Likelihood***		***Negligible 1***		***Minor 2***		***Moderate 3***		***Major 4***		***Extreme 5***	
Certain	*5*	*Yellow*	*5*	*Amber*	*10*	*Red*	*15*	*Red*	*20*	*Red*	*25*
Likely	*4*	*Yellow*	*4*	*Amber*	*8*	*Red*	*12*	*Red*	*16*	*Red*	*20*
Possible	*3*	*Green*	*3*	*Yellow*	*6*	*Amber*	*9*	*Amber*	*12*	*Red*	*15*
Unlikely	*2*	*Green*	*2*	*Yellow*	*4*	*Yellow*	*6*	*Amber*	*8*	*Amber*	*10*
Remote	*1*	*Green*	*1*	*Green*	*2*	*Green*	*3*	*Yellow*	*4*	*Yellow*	*5*

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

Action Required	*Person Responsible*	*Action Date*	*Action Taken*	*Completed Date*
Prepare SBAR to describe the performance of the contract, the authorised variations, service deductions and information around performance of the contract for the DoF annually and before the Unitary Payment is agreed for the following year.	*Donna Galloway*	*June 2020*		

Has the risk assessment been agreed with your line manager?	***Yes***	
Manager's Signature & Date  ***Gemma Couser, GM, WCCS*** ***16th December 2019***		
Have the findings of this risk assessment been communicated to all relevant people?	***Yes***	
Method(s) of communication ***Electronic distribution on Q pulse***		
Risk assessment completed by (print name & designation)		
Signature **Donna Galloway, Head of Laboratory Services**		***Date 28th November 2019***
How soon should this assessment be reviewed and how regularly afterwards? Bi-annually, when practices change or following an incident.		
Step 5- Review your assessment and update if necessary		
Review carried out by (print name & designation)		
Signature  ***Acting Head of Laboratory Services***		***Date 01/06/2021***
Signature		***Date***
Signature		***Date***
Signature		***Date***

This assessment should be reviewed immediately following an incident or if there have been significant changes in work activity

NHS Fife

Meeting:	**Finance, Performance and Resources Committee**
Meeting date:	**12 June 2022**
Title:	**Financial Improvement and Sustainability Programme Progress Report**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Maxine Michie, Deputy Director of Finance**

1 Purpose

This is presented to the Finance, Performance & Resources Committee for:

- Assurance

This report relates to:

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This paper outlines the progress to date of the Financial Improvement and Sustainability Programme.

2.2 Background

Through the SPRA process and FIS Programme we have identified a range of firm plans with the directorates to reduce costs during 2022/23. Each plan requires a Cost Improvement Plan template (CIP) to be completed which provides details of each plan covering actions required to take forward plans, savings trajectories, enablers, risks, timescales, and a quality impact assessment. Each CIP provides a robust audit trail of each plan from idea to delivery and any approved change control actions. A high-level summary of the current approved plans is identified in the table below.

SRO		Confirmed Schemes (SPRA)		
		Acute Services Directorate	£'000	£'000
		Procurement		
Acute	PCD	Instruments & Sundries & CSSD	1000	
Acute	PCD	Investment in Theatres Procurement/Cost Reduction	500	
		Service Commissioning		
Acute	PCD	Repatriation of Radical Prostatectomy	205	
Acute	W,C&C	Travel, Printing	60	
Acute	W,C&C	Managed Service Contract for Labs	425	
		Service Redesign		
Acute	W,C&C	Service Redesign - skill mix review	50	
		Pharmacy		
Acute	ECD	Pirfenidone and Nintedanib Homecare	40	
Acute	ECD	Patent Expiry / Homecare	160	
Acute	W,C&C	Community Paediatric Drugs	20	
		Supplementary Staffing		
		Reduction in Non core staffing	2000	
Acute	W,C&C	Vacancy Release	210	4670
		Pharmacy & Medicines Directorate		
Pharmacy		Medicines Efficiencies, PAS Rebates, Contract Changes	700	700
		Property & Infrastructure		
P&I		Major Contract Review	250	
P&I		Property Maintenance Minor Works Team	100	
P&I		Energy Savings - NDEE Project	150	
P&I		Rates Review	500	
P&I		Roster Review	250	
P&I		Terminate Lease For Evans Business Park	80	1330
		Vacancy Factor		
All	All	Vacancy Factor (less than 1% of total pays)	3000	3000
		Financial Grip & Control		
Finance	All	Financial Control across all areas of spend & financial flexibility/Accelerate from, Pipeline Projects where possible	2000	2000
		Total Identified	11700	11700

We have also identified a “Pipeline” of emerging potential plans which will contribute to closing the remaining underlying gap over the medium-term.

2.3 Assessment

During the first quarter of the financial year significant activity has been taken forward led by each Senior Responsible Officer (SRO), to develop and implement the approved cost improvement plans. A summary by SRO of the status of approved plans is included in the table below.

Within the Acute Services Directorate, a potential shortfall of £105k is likely to materialise against the approved schemes of £4.450m and pipeline projects are being worked up to mitigate the potential shortfall.

Medicines Cost improvement plans are on target to deliver, and other pipeline schemes are being developed.

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non-Rec £'000	Made up of:	Current RAG / Narrative against delivery of £11.7M within 2022/23 Financial Year
Acute Services Directorate	**4450**	**4345**		**14 CIP schemes – 2 in Development and 12 in Delivery**	**£105k Overall Shortfall –** pipeline projects being reviewed to mitigate
Pharmacy & Medicines Directorate	**920**	**638**	**262**	**20 CIP schemes** – 11 delivering recurring savings, 9 non-recurring making up in-year shortfall before all recurring savings kick in	**Confidence in delivery** – additional substantial schemes in Pipeline
Property & Infrastructure	**1330**	**1330**		**6 CIP schemes – all in Delivery**	**Confidence in delivery** – weighted towards last Quarter
Vacancy Factor	**3000**	**3000**		**Split across 10 directorates / areas**	**TBC**
Financial Grip & Control	**2000**	**2000**		**TBC**	CIP in Development
Total	**11700**	**11313**	**262**	**OVERALL RAG**	**Projected to deliver on Target**

Property and Infrastructure Schemes are also on target to deliver with almost 50% of planned schemes delivered to date.

The allocation of the Vacancy factor to directorates was approved at the June FIS board and will be largely taken forward in the remaining 9 months of the financial year.

The Financial Grip and Control target of £2m is currently in development with CIPS being worked up. However, it is likely that cost improvements will deliver against this target in the next month or 2.

A more detailed assessment of each SRO's cost improvement plans can be found in Appendix 1.

To the end of May, actual cost improvement delivered total £0.747m as per the table below against a plan of £1.638. The majority of the slippage in plans is in relation to the vacancy factor which was only approved and allocated to directorates for their May financial performance. The slippage within Acute services is in relation to vacancy factor also and it is anticipated this will be picked up in later months as actions are taken by the directorates.

Approved Cost Improvement Plans - Position at 31 May 2022

Budget Area	Current Year Target £'000	Year to Date Target £'000	Year to Date Achieved £'000	Year to Date Variance £'000
Acute	5,752	288	164	-124
Estates & Facilities	1,250	500	503	3
Corporate	4,698	850	80	-770
Total	**11,700**	**1,638**	**747**	**-891**

2.4 Recommendation

Members of the FP&R Committee are invited to take **assurance** the Financial Improvement and Sustainability Programme Progress to date.

Report Contact

Maxine Michie
Deputy Director of Finance
maxine.michie @nhs.scot

Appendices:
Appendix 1: Detail Assessment of CIPs by SRO

Appendix 1

Acute Services

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non-Rec £'000	Made up of:	RAG / Narrative
Investment & Sundries & CSSD (PCD)	1,000	1000		PCD001 Savings on Instruments & Sundries & CSSD	Savings profile begins July 2022
Investment in Theatres Procurement / Cost Reduction (PCD)	500	500		PCD002 Investment in Theatres Procurement Post to make savings once in post	Savings profile begins July 2022
Repatriation of Robotic Prostatectomies (PCD)	205	150		PCD003 Repatriation of Prostatectomy Services to be performed by robotic surgery with investment in Urology Consultant	£55k Shortfall – SLA with Lothian to be cancelled – process for this?
Travel, Printing (W,C&C)	60	62		WCCS001 Staff Travel Efficiencies	Delivered - £12k Over-delivery
		10		WCCS002 Printing & Stationary Efficiencies	Delivered – posted in ledger
Managed Service Contract for Labs (W,C&C)	425	150		WCCS004 Interventional Radiology Consumables	£50k shortfall
		100		WCCS005 Labs Demand Management	Delivered – posted in ledger
		25		WCCS006 Paediatric Surgical Sundries	Delivered
		100		WCCS008 MSC Saving	Delivered
Skill Mix Review (W,C&C)	50	1		WCCS007 T&R Uniform Savings	
		14		WCCS009 Blood Science Savings 8A	
		9		WCCS010 T&R Admin Saving	
			24	WCCS012 Labs 8A Retire & Return Saving	
Vacancy Release (W,C&C)	210	200		WCCS011 WCCS Vacancy Saving	Zero Delivery M1&2 – plan required
Reduction in Non-core Staffing (Directorate-wide)	2000	2000		**Reduction in Non-core staffing**	CIP in Development
Total	**4450**	**4321**	24	**OVERALL RAG**	**£105k Overall Shortfall**

Property & Infrastructure

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non-Rec £'000	Made up of:	RAG / Narrative
Major Contract Review	250	250		PI003 Major Contracts Review	Delivers Jun22
Property Maintenance Minor Works Team	100	100		PI002 Property Maintenance Minor Works Team	Delivers Dec22-Mar23
Energy Savings – NDEE Project	150	150		PI007 P&I Energy Savings - NDEE Project	Delivers Feb-Mar23
Rates Review	500	500		PI005 P&I Rates Review	Delivered April 22 – posted in ledger
Roster Review	250	250		PI001 P&I Roster Review - Sustainability Workforce	Delivers Dec22-Mar23
Terminate Lease for Evans Business Park	80	80		PI006 P&I Terminate Lease For Evans Business Park	Delivered April 22 – posted in ledger
Total	**1330**	**1330**		**OVERALL RAG**	**Projected to deliver on Target**

Medicines

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non-Rec £'000	Made up of:	RAG / Narrative
Pirfenidone and Nintedanib Homecare (ECD)	40	40		ECD001 Pirfenidone and Nintedanib Homecare	Delivered – posted in ledger
Patent Expiry / Homecare (ECD)	160	160			
Community Paediatric Drugs (WCCS)	20	20		WCCS003 Community Paeds Drugs Underspend	Delivered – posted in ledger
Medicines Efficiencies, PAS Rebates, Contract Changes (P&M Directorate)	700		184	PH001-007 PAS Schemes	On Target
		103		PH009 Change from Truxima (Napp) to Ruxience (Pfizer)	£136k recurring (£33k additional)
		228		PH010 Abiraterone Patent Expiry	£452k recurring (£224k additional
			16	PH012 Interim Medicine Pricing Agreement - Entyvio® (vedolizumab)	£43,200 non-recurring (£27k additional)
		23		PH013 NP36122 Antibiotics & Genito Urinary Branded & Generic Medicines	On Target (£2058 monthly from May 22)
		8		PH014 NP39722b Sorafenib/Thalidomide	£50539 recurring (£42k additional) **HORIZON SCAN**
		11		PH015 NP47722 CMU Bleeding Disorders	On Target (£1200 monthly starting July 22)
		29		PH018 NP35922c Pirfenidone	£70k recurring (£42k additional)
			62	(PH019) NP33922 Ranibizumab	On Target (£6860 monthly starting July 22)
		24		PH020 NP39722c Sunitinib	£29k recurring (£3,200 less than forecast)
		12		PH021 NP48922 Icatibant & C1 Esterase Inhibitor	On Target (£1318 monthly starting July 22)
Total	**920**	**658**	**262**	Non-recurring figure covers shortfall until recurring savings accrue in full into 2023/24	**Confidence in delivery** – £323k over-delivery plus additional substantial schemes in Pipeline

Vacancy Factor

Description (Original Confirmed Schemes)	Target £'000	CIP Recur. £'000	CIP Non-Rec £'000	Made up of:	RAG / Narrative
Vacancy Factor	3000	382		Acute Service Directorate	
		220		Digital & Information	
		141		Finance	
		1815		Service Level Agreement	Large target - Detailed CIP(s) required
		40		Public Health	
		65		Workforce	
		196		Pharmacy	
		5		Chief Executive	
		61		Medical Director	
		75		Nurse Director	
Total	**3000**	**3000**		**OVERALL RAG**	**Projected to deliver on Target**

NHS Fife

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE

PROPOSED ANNUAL WORKPLAN 2022/23

Governance - General							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action List	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Assurance Statement 2021/22	**Board Secretary**	✓					
Annual Internal Audit Report 2021/22	**Director of Finance & Strategy**		✓				
Board Assurance Framework (BAF)	**Director of Finance & Strategy**	✓	✓	✓	✓	✓	✓
Review of General Policies & Procedures	**Board Secretary**	✓			✓		
PPP Performance Monitoring Report	**Director of Property & Asset Management**				Private Session		
Internal Audit Review of Property Transaction Report 2021/22	**Internal Audit**	**As required**					
Strategy / Planning							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Annual Delivery Plan 2022/23	**Director of Finance & Strategy**	**Postponed (awaiting national guidance)**	Private Session	✓			

Strategy / Planning (cont.)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓			✓		
Annual Budget Setting Process 2022/23	**Director of Finance & Strategy**	Private Session					
Property & Asset Management Strategy (PAMS)	**Director of Property & Asset Management**		✓				
Fife Capital Investment Group Reports 2022/23	**Director of Finance & Strategy / Director of Property & Asset Management**	✓	✓	✓	✓	✓	✓
Orthopaedic Elective Project	**Director of Nursing**	✓		✓		✓	✓
Quality / Performance							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Integrated Performance & Quality Report	**Exec. Leads**	✓	✓	✓	✓	✓	✓
RMP4 / Winter Performance Report	**Director of Finance**	✓		✓ **Review**	✓ **Plan 2022-23**	✓	✓
Labs Managed Service Contract (MSC) Performance Report	**Director of Acute Services**		✓				
Linked Committee Minutes							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Fife Capital Investment Group	**Chair**	✓ 09/03	✓ 20/04	✓ 09/06 & 27/07	✓ 14/09	✓ 28/10 & 07/12	TBC
Procurement Governance Board	**Chair**			TBC	TBC	TBC	TBC

Linked Committee Minutes (cont.)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
IJB Finance & Performance Committee	**Chair**	**11/03 – deferred to next mtg**	✓ 11/03 & 29/04	✓ 08/07	✓ 16/09	✓ 11/11	TBC
Primary Medical Services Committee	**Chair**			✓ 07/06	✓ 06/09		✓ 06/12
Pharmacy Practice Committee	**Chair**	✓ 18/03	✓ 30/05	Ad-hoc Meetings			
Other / Adhoc							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Receipt of Business Cases	**As required**						
Consideration of awards of tenders	**As required**						
Asset Disposals							
Procurement Governance Board Report No. B18-22	**Internal Audit**		✓				
Financial Process Compliance Report No. B20-22	**Internal Audit**		✓				
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
CAT – Lucky Ewe Proposal	**Director of Property & Asset Management**	✓					
Kincardine & Lochgelly Health Centres Business Case	**Head of Capital Planning**	✓					
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme Proposal on Revised Final Business Case & Procurement	**Director of Pharmacy & Medicine**		Private Session				
Financial Improvement and Sustainability Programme Progress Report	**Director of Finance & Strategy**		✓				

Additional Agenda Items (Not on the Workplan e.g. Actions from Committee) *Cont.*							
	Lead	**10/05/22**	**12/07/22**	**13/09/22**	**15/11/22**	**17/01/23**	**14/03/23**
Corporate Risk Register - Draft Strategic Risks	**Director of Finance & Strategy/ Director of Pharmacy & Medicines**			✓			
Development Sessions							
	Lead						
FPR Development Session 1	**Director of Finance & Strategy**			✓ **21/09/22**			
FPR Development Session 2	**Director of Finance & Strategy**					✓ **25/01/23**	

FTF Internal Audit Service

Procurement Governance Board

Report No. B18/22

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance and Strategy

Kevin Booth, Head of Financial Services and Procurement
Michael Cambridge, Associate Director of Procurement, NHS Tayside and NHS Lothian

Paula Lee, Deputy Head of Procurement

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Performance and Resources Committee
Audit and Risk Committee
External Audit
Audit Follow Up

Contents

Draft Report Issued	9 March 2022
Management Responses Received	5 May 2022
Target Audit & Risk Committee Date	16 May 2022
Final Report Issued	**9 May 2022**

CONTEXT AND SCOPE

1. The NHS Fife Board Strategic Framework includes the objective of sustainability.

2. The NHS Fife Board Assurance Framework (BAF) includes Financial Sustainability, the following risk could threaten the achievement of this strategic objective –

   '***There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets***.'

3. The Procurement Strategy for NHS Fife 2019-2024 was approved at the September 2019 meeting of the Performance and Resources Committee. This Procurement Strategy sets out how NHS Fife intends to ensure that its regulated procurements will:

   - Contribute to the carrying out of its functions and the achievement of its purposes;
   - Deliver value for money;
   - Be carried out in compliance with its duties under section 8 of the Procurement Reform Act Scotland 2014

4. One area of Procurement has been identified within the Client COVID risk register presented to the EDG in July 2021 as a High level risk:

   - *Risk 1878 - As services remobilise, the impact on the Procurement function and its resources is unknown and currently unquantified. Anticipate pressures on product demand, requirements for PPE and cleaning products and Procurement BAU functions. Risk for the Procurement function handling the competing demands of the operational requirements (post-COVID PPE/stock management/mass vaccination clinics requiring a trial of a pull model (agreed at bronze group) to help deliver the stock to each independent location- involving a lot of planning) versus strategic requirements (remobilisation, return to pre-COVID BAU, longer-term procurement activity).*

   The Procurement Risk Report presented to the January 2022 meeting of the Procurement Governance Board shows that this risk has decreased from a High level of risk to a current status of Moderate.

5. Our audit will evaluate the design and operation of the controls and will specifically consider whether:

   - The governance arrangements of the Procurement Governance Board (PGB) and scope of its remit are operating as stated;
   - the Procurement Governance Board has appropriate oversight and monitoring over the Procurement Strategy; the procurement workplan; risk management and performance monitoring mechanisms.

AUDIT OPINION

6. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

Executive Summary

7. The ever increasing challenges of the COVID environment has impacted the operation of the PGB, we have identified improvements and recommendations to enhance the current Procurement arrangements within the following areas: the frequency of the PGB meetings, the Terms of Reference of the PGB, the assurances to the Finance, Performance and Resources Committee, the reporting of KPIs and the inclusion of further data, where possible, within the Procurement Annual Report on the progress of Procurement Strategic objectives.

Procurement Governance Board (PGB)

8. The Terms of Reference of the PGB, state the PGB is accountable to the Executive Directors Group for the achievement of the objectives associated with the Procurement Strategy.

9. The Procurement Strategy was approved by the Finance, Performance and Resources Committee (FP&RC). Procurement is a key function which will require to demonstrate value for money. The FP&RC has a specific responsibility to keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. We are of the view that the PGB should report and be accountable to the FP&RC as a Standing Committee of the Board and the EDG should be provided with updates from the PGB. The Annual Procurement Report for 2020/21 has been considered at the 3rd of February 2022 Executive Directors Group (EDG) and provides an update on the Procurement Strategy and associated work streams. The SBAR on the Annual Procurement Report presented to the February 2022 EDG meeting recommended approval to publish the report and for subsequent presentation and approval to the 15 March 2022 meeting of the FP&RC, thereafter published on the NHS Fife website.

10. The Procurement Teams capacity has been disrupted with the increased workload associated with responding to the pandemic, along with staff turnover and changes within the team. Additional support was secured in January 2021, with the Associate Director of Procurement for NHS Tayside and NHS Lothian acting as an advisor/ peer to support the PGB. There has been further investment with the recent recruitment of the Deputy Head of Procurement to NHS Fife and the introduction of a work based learning course for a number of the procurement team to enhance the capability and capacity of the team.

11. The Terms of Reference state that the PGB will meet on a quarterly basis whereas recently, it has met every six months, in January and July 2021 and in January 2022.

12. National Procurement provided NHS Fife with an Annual Workplan and a quarterly GAP Report to highlight the National Contracts that have been added or are due to become available to all NHS Boards in the coming year. The SBAR on the Engagement plan to the January 2022 PGB advised that the Head of Procurement is working on an engagement plan with services to look for any efficiency or savings opportunities that the National Procurement Workplan / Quarterly GAP Report may provide, and this will inform the development of the Local Contracting Workplan. We recommend that the Local Contracting Plan should include priorities, key deliverables, milestones and timescales, where aspects of the projects are identified to ensure effective monitoring and achievement of the objectives and is regularly presented to the PGB as a standing item.

The scope of the Terms of Reference

13. The PGB has an agreed Terms of Reference (ToR) which covers the following:

    - Chair - (Director of Finance and Strategy)
    - Purpose of the Board
    - Governance structures and reporting lines
    - Has a multi-disciplinary diverse membership including representatives from the Partnership
    - The quoracy is stated
    - The PGB is to provide the oversight arrangements, of the objectives of the Procurement Strategy
    - The PGB will maintain a set of Key Performance Indicators

    There is scope to further clarify the governance arrangements within the PGB Terms of Reference, by including the PGB's strategic reporting arrangements to the FP&RC; oversight of the Annual Procurement Report and delivery of value for money and the operational reporting arrangements to the EDG. In addition, any relevant groups which report to the PGB should be identified.

Oversight of Procurement Strategy by the Procurement Governance Board (PGB)

14. The Procurement Strategy 2019-2024 states that '*progress against the Strategic Objectives will be reported to the NHS Fife Board by presentation to the Performance and Resources Committee annually*.' In practice this is discharged through the presentation of the Annual Procurement Report, to the Finance, Performance and Resources Committee (FP&RC) following the end of the Financial Year.

15. The Annual Report for April 2020 to March 2021 has been delayed this year. The SBAR presented to the 3 February 2022 EDG meeting, recommended approval to publish the report and for subsequent presentation and approval planned for to the 15 March 2022 meeting of the FP&RC, thereafter published on the NHS Fife website. We recommend that the Annual Report is prioritised to enable the assurance on this area to be reported to the FP&RC as part of the year end assurances. An agenda setting plan would facilitate this process.

16. The Annual Procurement Report April 2020 to March 2021 includes the Procurement Strategy Objectives with actions and status. There is further scope to enhance the information on the next reiteration, by including further data where it is possible to show incremental milestones, improvements and achievements on objectives.

Performance Monitoring

17. The Procurement Strategy states that the Key Performance Indicators (KPIs) will be reported to the Chief Executive and Executive Directors Group on a monthly basis. The PGB ToR states the PGB will maintain a set of Key Performance Indicators. However, the KPIs were only included within the Annual Procurement Report 2020/21 and have not been reported to the Chief Executive, PGB meetings, or to the EDG. The KPIs are an integral part of the management information and oversight and may provide assurance or highlight areas of concern where improvements are required and should be regularly reported.

Reporting of Procurement Risks

18. Procurement Risk Reports were presented to the July 2021 and the 28 January 2022 meetings of the PGB. Our review of these risks demonstrate effective risk management arrangements in place and actions implemented to reduce the effects of high risks and a re-evaluation of the risk after actions have been addressed.

19. There were six Procurement risks, reported to the January 2022 meeting of the PGB, two which were high risks, referring to the staffing/department capacity and service delivery. Each had appropriate mitigating actions to address these risks. The remaining four risks have a rating of moderate or low.

20. The SBAR on procurement related risk to the January 2022 meeting of the PGB provided assurance as follows:

    - that a formal review of all Procurement related Datix risks takes place on a fortnightly basis and
    - COVID-19 risks were actively originally managed via the now stood down Procurement Silver Command Group and are now reviewed by the Procurement Management Team and members of the Critical Supplies Technical User Group.

ACTION

21. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1	
Finding:	
The Terms of Reference of the PGB states it will meet on a quarterly basis whereas over the last year it has met every six months, with meetings in January & July 2021 and January 2022. The Procurement Teams capacity has been disrupted with the increased workload associated with responding to the pandemic, along with staff turnover and changes within the team.	
Audit Recommendation:	
The Procurement Governance Board should reconsider and review the frequency of meetings in relation to the business agenda of the Procurement Governance Board, to reprioritise the items required to enable effective oversight and ensure all the business of the Procurement Governance Board is covered. Alternative arrangements such as virtual approval of the items should be considered.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The Procurement Governance Board had planned to meet more regularly during 2021/22 however the meetings were paused in response to the pandemic. We will prepare a proposal to be contained within the Terms of Reference which recommends quarterly meetings of the group to allow effective oversight of the items necessary for it to fulfil its remit.	
Action by:	**Date of expected completion:**
Head of Financial Services and Procurement	**30 September 2022**

Action Point Reference 2	
Finding:	
The PGB has an agreed Terms of Reference (ToR) which covers the following: Chair - (Director of Finance and Strategy); Purpose of the Board; Governance structures and reporting lines; Has a multi-disciplinary diverse membership including representatives from the Partnership; The quoracy is stated, the PGB is to provide the oversight arrangements, of the objectives of the Procurement Strategy and the PGB will maintain a set of Key Performance Indicators.	
Audit Recommendation:	
We recommend the planned review of the PGB Terms of Reference clarifies the governance arrangements, by including the PGB's strategic reporting arrangements to the FP&RC; oversight of the Annual Procurement Report and delivery of value for money and the operational reporting arrangements to the EDG. In addition, any relevant groups which report to the PGB should be identified.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	

The Procurement Governance Board will be asked to review their Terms of Reference, including clarification of its governance arrangements and responsibilities.
Specifically this will include:
• **the PGB's strategic reporting arrangements to the FP&RC**
• **the operational reporting arrangements to the EDG.**
• **Identification of any relevant groups which report to the PGB**
• **its responsibilities for**
  ○ **oversight of the Annual Procurement Report**
  ○ **delivery of value for money.**	

Action by:	**Date of expected completion:**
Head of Financial Services and Procurement	**30 September 2022**

Action Point Reference 3	
Finding:	
The Procurement Strategy 2019-2024 states that '*progress against the Strategic Objectives will be reported to the NHS Fife Board by presentation to the Performance and Resources Committee annually.*' In practice this is discharged through the presentation of the Annual Procurement Report, to the Finance, Performance and Resources Committee, following the end of the Financial Year. The Annual Report has been delayed this year. The SBAR presented to the 3rd of February 2022 EDG meeting recommended approval to publish the report and for subsequent presentation and approval planned to the 15 March 2022 meeting of the FP&RC.	
Audit Recommendation:	
We recommend that the Annual Report is prioritised to enable the assurance on this area to be reported to the FP&RC as part of the year end assurances. An agenda setting plan should be implemented to ensure the business of the PGB is covered over the year.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The timing of the Annual Report will become part of the department's internal workplan and we will ensure a more timely completion this year. **An annual workplan for the PGB scheduling reporting to it throughout 2022/23 will be developed and agreed by the PGB.**	
Action by:	**Date of expected completion:**
Head of Financial Services and Procurement	**30 September 2022**

Action Point Reference 4	
Finding:	
The Procurement Strategy states that the Key Performance Indicators (KPIs) will be reported to the Chief Executive and Executive Directors Group on a monthly basis. We note the KPIs were only included within the Annual Procurement Report 2020/21 and have not been reported to the Chief Executive, PGB meetings, or to the EDG. The KPIs are an integral part of the management information and oversight and may provide assurance or highlight areas of concern where improvements are required and should be regularly reported.	
Audit Recommendation:	
We recommend that a balanced scorecard is implemented with KPIs and presented to the PGB, Chief Executive and EDG on a monthly basis in line with the Procurement Strategy.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The KPIs will be reported quarterly to each meeting of the PGB and EDG. The Procurement Strategy will be updated to reflect this.	
Action by:	**Date of expected completion:**
Head of Financial Services and Procurement	**30 September 2022**

Action Point Reference 5	
Finding:	
The Annual Procurement Report April 2020 to March 2021 includes strategic objectives with actions and status. There is further scope to enhance the information on the next reiteration, by including further data where it is available to demonstrate achievements on objectives over the year. The Risk Management arrangements are not referred to within the Annual Procurement Report	
Audit Recommendation:	
We recommend the next reiteration of the Annual Procurement Report includes: • further data where it is possible, to demonstrate incremental milestones, improvements and achievements on the strategic objectives • Risk management arrangements and a summary of the risks and movements during the year.	
Assessment of Risk:	
Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	
Management Response/Action:	
Further information where possible will be included in the next Annual Report, to better highlight achievements/progression. **With regards to the Risk Management, we are happy to draw reference across the Annual Report where required.**	
Action by:	**Date of expected completion:**
Head of Financial Services and Procurement	**30 April 2023**

Section 4 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Section 4 Definition of Assurance and Recommendation Priorities

Assessment of Risk

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

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

FTF Internal Audit Service

Financial Process Compliance

Report No. B20/22

Issued To: Carol Potter, Chief Executive
Margo McGurk, Director of Finance and Strategy

Kevin Booth, Head of Financial Services & Procurement
Caroline Leitch, Head of Finance - Reporting & Analysis
Anne Marie Hayter, Payment Manager (Financial Services)

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Audit and Risk Committee
External Audit
Audit Follow Up

Contents

Draft Report Issued	28 April 2022
Management Responses Received	05 May 2022
Target Audit & Risk Committee Date	18 May 2022
Final Report Issued	**9 May 2022**

CONTEXT AND SCOPE

1. The Internal Audit Strategic Planning Process recognises that not all systems are subject to full review every financial year. Where full audits are not carried out, high level financial process compliance (FPC) audits are carried out in order to provide assurance on the operation of key financial systems.
2. The results of our work directly inform the Chief Internal Auditor's statement on financial controls within the Annual Report.
3. The scope of this review was to provide assurance that, for a sample of key financial systems, processes and procedures are established and meet the requirements of the Financial Operating Procedures (FOPs) and the relevant parts of the Standing Financial Instructions. This exercise tested outputs from and certain procedures within those financial systems.
4. This audit tested the adequacy and effectiveness of key controls in:
   - Accounts Payable
   - Budgetary Control

AUDIT OPINION

5. Due to the limited nature of the review undertaken, we have not provided a full audit opinion on each system. However, based on the testing carried out, we can find no evidence to suggest that either system is failing to meet business objectives.
6. The Financial Operating Procedures (FOPs) form part of the internal control system of the NHS Fife Board. A comprehensive review and update of the FOPs was undertaken by the Head of Financial Services and thereafter presented and approved at the December 2021 Audit and Risk Committee.
7. A description of the assessment of risks is provided in Section 3 of this report.

Accounts Payable

8. From our high level review and sample testing of the Accounts Payable system we concluded that:
   - High level testing confirmed that key controls for the system were in place and operating effectively.
   - In line with the FOPs, BACS payment runs for Accounts Payable are carried out three times a week. Testing confirmed that the BACS and cheque payments examined were appropriately authorised, and independently verified. BACS payments over £10,000 were reviewed by the Payment Manager.
   - Invoices examined were correctly coded, appropriately authorised and invoices were passed to the Accounts Payable Department in a timely manner.
   - Financial Services management prepare a monthly monitoring return report to the Scottish Government which includes prompt payment reporting. This summarises performance against the payments made within 10 days target and also payment made within 30 days.

- Prompt payment policy performance as at January 2022 was as follows:

Payment Policy	January 2022	Cumulative Year to January 2022
Total of Invoices Paid within 30 Days		
% by volume of invoices paid within 30 days	89.26%	91.6%
% by value of invoices paid within 30 days	95.27%	95.54%
Aspirational 10 day target		
% by volume of invoices paid within 10 days	71.02%	78%
% by value of invoices paid within 10 days	88.72%	90.04%

9. We reviewed the Invoice Register weekly report for 7 of March 2022, a report which shows a cumulative record of unpaid invoices and the dispute code with reasons why these cannot be processed for payment. The report shows the Directorate and department codes and our analysis shows the following disputed invoices:

Directorate/ Department (Identified by Prefix Code)	Number of Disputed Invoices	Percentage
General (Theatres, catering etc)	2,967	40.8
Other (No Prefix Code)	1,990	31.4
Estates	728	10.6
eHealth	728	10.6
Procurement	401	5.8
Laboratory	60	1.0
Total	**6,874 (Approximate Value £18.6m)**	**100**

10. We reviewed and analysed the Invoice Register weekly report for 7 of March 2022 to ascertain the reasons why the invoices were disputed and concluded the following reasons for the delay in processing in descending order:

Reason for Dispute	Number	Percentage
Awaiting Authorisation	1783	26
Awaiting Receipt	1320	19.2
Awaiting Credit Note	762	11.1
Purchase Order Addition	732	10.6
Query Price	667	9.7
Unknown (reason not shown)	449	6.5
Disputed Invoice	443	6.4
Partial Receipt	364	5.3
Invoice Returned to Supplier	129	1.9
Query Goods	129	1.9
Query Quantity	96	1.4
Total	**6,874**	**100**

11. Further analysis should be undertaken by the Payment Manager on the Invoice Register to review the reasons why there are delays, in particular why Awaiting Authorisation and Receipt are an issue, to ascertain if the departments could receipt these more quickly and therefore be completed within PECOS more promptly. A regular report should be prepared with analysis on the Invoice Register to inform the Executive Directors Group (EDG) of the continued issues and reasons for disputed invoices and outlining the actions that can be taken to resolve them until the number of disputed invoices are reduced. We note that a report regarding the issues of prompt authorisation and receipt to the Directorates and Departments has been shared with EDG colleagues by email for them to disseminate.

12. For Query on Price, a process is in place where Accounts Payable send the Invoice Register to the Procurement Department to review any price query and the Procurement Department carry out checks against the relevant contract and update PECOS. The Head of Procurement informed Internal Audit that the issue for price query related to the process for the updating of PECOS to changes in price and the Procurement Department were experiencing challenges with the workload due to the effects of Pandemic and Brexit. We were verbally assured by the Head and Deputy Head of Procurement that an agreement has been reached with Accounts Payable and Procurement to improve this issue.

Budgetary Control

13. From our high level review and sample testing of the accounts payable system we concluded that:

    - Budget holders signed for their respective budgets at the beginning of the financial year.
    - We are satisfied that monthly reports are provided to budget managers using a standard format and that appropriate support to budget managers is provided by the Management Accounts Team.
    - A timetable is in place for the production and distribution of standard reports with appropriate review undertaken by senior management.

ACTION

14. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1	
Finding:	
We reviewed the Invoice Register weekly report for 7 of March 2022, to ascertain the reasons why the invoices were disputed and concluded that Awaiting Authorisation and Receipt were the key reasons for the delay in processing.	
Audit Recommendation:	
Further analysis should be undertaken by the Payment Manager on the *Invoice Register* to review the reasons why paid invoices are being delayed, in particular why *Awaiting Receipt and Authorisation* causes delay to ascertain, if the departments could receipt these more quickly and therefore could be completed within PECOS more promptly. A report should be prepared with analysis on the Invoice Register to inform the Executive Directors Group of the issues and reasons for disputed invoices and outlining the actions that Directorates and Departments can take to resolve them.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
An initial report has been circulated to EDG members for them to disseminate and a regular report will be provided to EDG on this issue until the number of invoices awaiting being receipted is at expected levels on a consistent basis.	
Action by:	**Date of expected completion:**
Kevin Booth, Head of Financial Services & Procurement	**31 August 2022**

Section 3 Recommendation Priorities

Assessment of Risk

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

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

MINUTE OF FIFE CAPITAL INVESTMENT GROUP MEETING

Wednesday 20 April 2022, 9.30am
Via MS Teams

Present: Neil McCormick, Director of Property and Asset Management **(Chair)**
Dr Chris McKenna, Medical Director
Alistair Graham, Associate Director of Digital and Information
Maxine Michie, Deputy Director of Finance.
Ben Johnstone, Director of Capital Projects
Claire Dobson, Director of Acute Services
Tracy Gardiner, Capital Accountant
Rose Robertson, Assistant Director of Finance
Jim Rotheram, Head of Facilities
Wilma Brown, Employee Director

In Attendance: Bryan Davies, representing Nicky Connor.

1.0 WELCOME AND APOLOGIES

Apologies were received from Margo McGurk, Director of Finance, Jannette Owens Director of Nursing, , Nicky Connor, Director of HSCP and Paul Bishop, Head of Estates.

2.0 NOTES OF PREVIOUS MEETING

The note of the meeting held on 9 March 2022 was agreed as an accurate record.

3.0 ACTION LIST

The Action List was updated accordingly.

4.0 MINUTES OF OTHER COMMITTEES

4.1 Clinical Prioritisation Group (NMcK)

The minutes were noted.

5.0 MATTERS ARISING

N/A

6.0 PROPOSALS TO ALLOCATE FORMULARY CAPITAL 2022/23

6.1 Capital Equipment Management Proposal (RR)

RR presented the proposal on behalf of CEMG to allow FCIG to inform the distribution of capital funding for 2022/23. It was highlighted that significant capital equipment funding was received last year, this allowed acceleration of replacement plans. The minimum requirement for CEMG in 2022/23 is circa £450k. This includes £144k opening commitment for items ordered in the previous year but were not delivered, £100k for replacement of condemned equipment and CT Scanner enabling work £207k. These funds must be achieved in 2022/23. Appendix 1 details the CEMG Equipment replacement plan which totals £3.3m, it is recognised that there is a limited budget this year therefore CEMG will prioritise 3 of the 6 General X-Ray Rooms, then seek additional funding from Mike Conroy.

A recommendation of £1.5m of capital allocation has been proposed and discussed with the Deputy Director of Finance, if this was allocated this would allow for 3 of 6 General X-Ray Rooms to be progressed leaving £290k additional funds for replacement of other core capital equipment which is required. This initial allocation does have a level of risk attached as it does not cover the full amount required however, the submission to the National Equipping Group and potential funding received as a response to that will hopefully mitigate some level of risk.

FCIG noted the proposal.

6.2 Estates, Facilities and Capital Planning Proposal (NM/BJ/JR)

BJ presented the proposal on behalf of Estates, Facilities and Capital Planning. Historically, £4m is allocated for statutory compliance, backlog maintenance, minor projects and clinical prioritisation. However, due to awareness of budget constraints this year an initial £2.7m was proposed. Following discussions with the Deputy Director of Finance this was amended to £2.65m.

FCIG were guided to section 2.3 of the report notes how the £2.65m will be allocated. £2.23m to backlog and statutory compliance, £100k to transport, £70k to capital planning to support developing the strategic master plan for VHK site and £250k to clinical prioritisation which will support emerging priorities. Some schemes such as dermatology has not been allocated funding this year which will need to be discussed.

There is £1.5m expected for QMH which was proposed last year.

There is a long-term mental health inpatient anti-ligature process in place over the next 5 years, interim work will be done in the short term to support this. The Partnership has received some additional funding and are looking for some of this to be used for anti-ligature work.

The resources are constrained this year however, are aiming to try and prioritise what they can this year. A more long-term plan is in place this year which has allowed for better prioritisation.

The recommendation is for £2.65m.

It was agreed that further discussions are required on dermatology and orthopaedic offices to identify further funding to allow work to progress on these plans this financial year. It was agreed that this should be viewed as priority.

MMi agreed to discuss and take this forward.

FCIG noted the proposal.

6.3 Digital and Information Proposal (AG)

AG presented the proposal on behalf of Digital and Information, FCIG were guided to table 1 within section 2.3 of the paper. It was noted that the first couple of items detailed within the plan for 2022/23 relate to endpoint devices such as PC and Laptops. The team have been fortunate to have been provided with some additional allocation in 2021/22 which has been used towards replacement of devices, which means this is no longer required this financial year. There is a commitment to Trak care infrastructure which missed year-end and was carried forward to 2022/23. A larger item for D&I which is required this year is the replacement of Data Centres onsite at VHK and QMH due to them being outdated, the cost noted is based on historical costs, a tender will be undertaken to ensure best value as this is pursued in 2022/23. Other items noted within the proposal relate to the replacement of the telephony system, over the last few years the changes in our communication technology are significant. A high-level strategic group will be set up to identify what is required by the board as this project moves forward. There will be consideration of the new ways of working to ensure communication can be enhanced.

It was noted that the paper includes a detailed risk assessment of the capital proposal.

FCIG noted the proposal.

6.4 Capital Budget 2022/23 (MMi)

MMi presented the Capital Budget 2022/23 to the group. It was noted that the Board has approved the Financial Plan for 2022/23 which includes a capital to revenue transfer of £2m. This presents a challenge to take forward the plans detailed within the Capital Proposals and allocate the funds available effectively.

On 18 March 2022, the Board was asked to submit a capital plan to the Scottish Government as part of the Financial Plan 2022/23. The plan sets out what should be expected to come forward for the next 5 years and details the ask from Scottish Government and the formulary allocation. The plan also details £200k which should be paid to Scottish Government each year, however, NHS Fife have agreed to defer this payment this financial year.

The starting point for formulary capital is £7.374m this year, which is a 5% uplift. Due to the capital to revenue transfer, this will decrease by £2m, which will take the pressure of the revenue budget in 2022/23. A number of capital projects were brought forward in 2021/22 as the £10m additional resource was received. £700k requires to be re-allocated to the QMH allocation. £5m requires to be allocated over the various projects discussed this morning.

The paper details the priorities for this financial year, it was highlighted that the plans received today were considered alongside the SPRA. The paper outlines the proposal for overall allocation of the budget this year.

For example, £1m allocated last year for digital and information, this year £877k is proposed.

The National Infrastructure Board has requested a submission detailing the Equipping Requirement for the next 2 financial years. If additional resource becomes available, this will be used to allocate funds.

£1m was issued by Government to Partnerships to support the Mental Health Estate. This will provide opportunity to take forward spend on of revenue nature and to support projects where possible if the Scottish Government is in agreement.

In terms of the SPRA, projects which will be picked up this financial year include; QMH theatre refurbishment, local decontamination, radiology rooms and roll out of digital pathology. Other projects will be picked up but due to priorities and further analysis these may go into 2023/24.

7.0

FCIG agreed the split of the Capital Budget 2022/23 that is detailed within the report with the caveat that Dermatology and

GOVERNANCE

7.1 Orthopaedic Project Update (BJ)

BJ noted that work is progressing well, the project is maintaining programme and completion is scheduled for October 2022. The year-end spend for 2021/22 was achieved. There is contingency spend remaining within the project.

FCIG noted the update.

7.2 Kincardine & Lochgelly Project Update (BJ/BD)

BJ noted that the OBC's for both Kincardine and Lochgelly are progressing through the governance cycle. The next milestone is Finance, Performance and Resources Committee on 10 May 2022, followed by NHS Fife Board Meeting on 31 May 2022.

The milestone plan is expected to be submitted to Scottish Government at the end of May 2022. Work has commenced on the Stage 2 design stage

The key risks of the project relate to the expected NHS Assure Report which is due to be received, at present it is unclear what may be found in that report, There is also a risk relating to Sustainability, Health Improvement Scotland are asking that the briefing is changed.

BD highlighted that a presentation was given on the service model at the last project board meeting for assurance purposes, this highlighted the robust process followed early on to develop the proposal to ensure it was in line with the needs of patients. This was well received.

Terms of Reference for both project working groups and action plans have been developed. Work should progress to ensure by December 2022 the full service model will be fully developed.

BD noted that premises costs is being discussed with both AV and MMi to identify and agree principles and a way forward. A meeting has also been set up with Forth Valley to discuss liability in relation to Kincardine due to the boundary issue, it is hoped that a meeting to discuss who will provide which services will allow a pathway and way forward to be agreed.

FCIG noted the update.

7.3 Mental Health Strategy (BJ)

BJ noted that optional appraisal process with stakeholders has commenced, workshops start on 22 April 2022, the optional appraisal process will be complete in May 2022. This will help inform the service model for Mental Health Inpatients.

FCIG noted the update.

8.0 **7.4 Review of Annual Workplan (NMcK)**

FCIG approved the workplan.

PERFORMANCE

8.1 Capital Expenditure Report Update (TG)

TG noted that they ultimately landed a £33m Capital Programme for 2021/22. A few
9.0 items of equipment were not received by year end; however, slippage was managed within the programme. Targets were achieved.

FCIG noted the update.

10.0

ISSUES TO BE ESCALATED TO EDG

N/A

AOCB

N/A

11.0 DATE OF NEXT MEETING

1pm, 9 June 2022 via MS teams.

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE FINANCE & PERFORMANCE COMMITTEE FRIDAY 11 MARCH 2022 AT 10 AM VIA MICROSOFT TEAMS

Present:	Cllr David Graham [Chair] Martin Black, NHS Board Member Cllr Rosemary Liewald Cllr David Alexander Arlene Wood, NHS Board Member
Attending:	Audrey Valente, Chief Finance Officer Fiona McKay, Head of Strategic Planning, Performance & Commissioning Rona Laskowski, Head of Critical and Complex Care Services Bryan Davies, Head of Integrated Primary and Preventative Care Services Norma Aitken, Head of Corporate Service, Fife H&SCP *In attendance*: Tim Bridle, Audit Scotland Katie Caldwell, Carol Notman, Personal Assistant (Minutes)
Apologies for Absence:	Nicky Connor, Director of Health & Social Care Helen Hellewell, Associate Medical Director Euan Reid, Lead Pharmacist Medicines Management

		Action
1.	**WELCOME AND APOLOGIES** Cllr Graham thanked everyone for attending the committee meeting and welcomed Katie Caldwell and Tim Bridle to the meeting.	
2.	**DECLARATIONS OF INTEREST** There were no declarations of interested noted.	
3.	**MINUTE OF PREVIOUS MEETINGS – 14 JAN. 2022** Minutes were agreed as an accurate record of the meeting	
4.	**MATTERS ARISING / ACTION LOG – 14 JAN. 2022** The action log was reviewed and discussed.	
5.	**FINANCE PAPER** Audrey Valente noted that the report presents the projected outcome position at December 2021 for Fife Council and January 2022 for NHS Fife Services.	

	She advised that the Partnership is projecting an underspend and there has been little movement from the situation reported for November 2021. Audrey advised that further funding of £981M from Scottish Government has been announced in the last few weeks. This funding has been made available to Health Boards and HSCP. Audrey confirmed that Fife's share of this funding is £43m and advised that any money remaining at the end of the financial year will be carried forward in line with the usual funding arrangements in place. Audrey advised that there are various risks and mitigations outlined in the report, noting that while this funding is welcomed the Partnership needs to continue with the transformation programme as the funding is not recurring. Arlene Wood asked with regards the recommendation (Section 3.4) re the decision to use reserves whether a direction was required to use this funding. Audrey thanked Arlene for the query and advised that she will investigate this as part of the transformation programme going forward. Martin Black wished to stress the importance of keeping covid funding available, noting that although covid restrictions are reducing, the infection remains within the community and there was always the possibility that restrictions may need to be put back in place. Audrey assured the committee that the Local Mobilisation Plan (LMP) was still in place and the Partnership recognised that there will still need to budget for covid costs next year. David Graham thanked Audrey and confirmed with the committee, taking into consideration Arlene's observation regarding the reserves which Audrey will consider and update the committee, that the recommendations had been agreed.	**AV**
6.	**REVENUE BUDGET 2022-25** Audrey Valente presented paper on the Revenue Budget 2022-25 which provides information on the budget gap up to 2025. Audrey noted that additional funding has been made available, but despite this additional investment there remains a financial gap. She assured the committee that the figures will be continually refined as more accurate information becomes available. Audrey advised that the key message within the report is that the Partnership is asking for the Year 1 Budget is approved with the Medium-Term Financial Strategy (MTFS) being deferred and produced later in the year. Audrey confirmed to reach a balanced budget the current value that remains undelivered is £3.7M and assurance had been given that savings will be delivered in the next financial year. She noted that there are 2 PIDS requiring temporary support from reserves. Audrey confirmed that the Set-Aside is currently £6M overspend in health services. Audrey noted that the paper outlines the key cost pressures for the Service is the Primary Care Improvement Plan, which has been recognised and additional funding has been provided, and Transitions for children coming into the adult services with no budget. Audrey advised that the £3M gap for Transitions has been included in the budget for next financial year and has not affected the balanced budget for 2022-23. David Graham noted his frustrations with regards the Set Aside, as this issue has been ongoing for some time and queried why it was taking so long. Audrey advised that it is not a Finance led function but rather Service led and from her perspective as Chief Finance Officer there is a problem of £6M which will be coming across to the Partnership. She confirmed that there have been	

	regular ongoing discussions with key personnel and it had been planned for it to come across during this financial year but due to the pandemic it was not considered a high priority. Audrey advised that she was confident once the delivery model has been finalised that the set aside will be moved. Arlene Wood advised that she was uncomfortable only setting a 1-year finance budget given the transformation programme and the need for longer term planning of sustainable services and also as it appears that the partner bodies have not agreed the budget. Audrey Valente advised that there is a Statutory Obligation to have an approved budget and confirmed that the Partner Bodies had given the Partnership notification of the budget. She confirmed that Fife Council's budget had been approved in February 2021, but NHS Fife's had not progressed through all their governance channels therefore would not be signed off until May 2022. Audrey confirmed that deferring the longer term plans would only be for 3-4 months. David Graham asked Carol Notman to add this to the action plan for July 2022 Meeting. Martin Black noted that the was uncomfortable saying that the Partnership will be bringing in a balanced budget when there is a deficit of £6M in set asides that will be coming across to the Partnership at some point. Audrey advised that this has not come across formally to the IJB at this point and noted that she hears the concerns of the Committee and confirmed that discussions still required to take place but currently the Partnership was not in position to discuss and include it. Martin queried why the Partnership was going to provide additional funding of £1M to Primary Care if it was not going to have any control over what happened with the funding. Audrey Valente confirmed that the Scottish Government provides the Partnership with funding for the Primary Care Improvement Plan who acts like a post box for this funding. Bryan Davies confirmed that funding had been provided with specific instructions that it is used for Community Treatment Access Centres, Pharmacotherapy and the Vaccination Programme. Bryan confirmed that monitoring the progress of the implementation is undertaken by the GMS Implementation Group which regularly provides updates to the Clinical & Care Governance Committee and the Scottish Government Health Department. David Alexander noted while he was delighted with the current budget position, he feared going forward that although there would not be a reduction in budget there would be an increase in demand. Audrey Valente advised that additional costs is a certainty, the level of detail is not known at this point but is being looked at nationally. Martin Black reminded all of the ongoing pressures that are going to hit the NHS, Fife Council and the people of Fife with increased energy costs. He noted that this will likely have detrimental effect for the mental health and malnutrition of the people of Fife and in turn the services supporting these people. Bryan Davies advised that the services are planning to hold information sessions in April and noted that the two new health care hubs in Lochgelly and Kincardine that will be opening soon will be providing support services delivered to the public as outlined in the Primary Care Strategy. Audrey Valente confirmed that additional funding has been provided to the Mental Health Team in anticipation. She noted with regards increased energy costs for the Partnership will be managed from the reserves next year but acknowledged that this was a short-term solution. David Alexander advised that the Scottish Government will be providing support to people who are struggling with funding being provided to Local Authorities.	**CN**

	David Graham noted that, with the agreement that the plan will be provided at the July 2022 meeting, the committee were happy to accept the recommendations.	
7.	**PERFORMANCE REPORT** Fiona McKay advised that this report was the usual performance report that is tabled at the committee every second meeting. Fiona noted that the content of the report was being currently reviewed and she was a member of the group that was looking at the definitions of what is classed as performance and what is quality as these are reported separately depending on the subject matter. In addition, Fiona confirmed that she is also planning to investigate how Fife compared with the rest of Scotland with regards the MSG Indictors and Best Value. Arlene Wood queried with regard Capacity and Flow, noting that the hospital emergency admissions, A&E and delayed discharge numbers had increased and asked when an improvement was likely to be seen. Fiona McKay advised although the emergency admissions sit with us they are A&E Targets which is part of the set-aside. She acknowledged that the increased admissions had impacted on delayed discharges but confirmed that Lynne Garvey, Head of Community Care Services had been working closely to ensure that people are not admitted at the front door if they don't need to be. A Settling Service has been introduced at A&E to support those who are ready to go home. This service has been in place for 3 weeks and is being funded from the Scottish Government Health Department. Arlene Wood queried when the committee would commence seeing the Mental Health Indicators within the Performance Report. Fiona advised that it was her understanding that the Mental Health Indicators would be included in the Quality Report submitted to Clinical & Care Governance Committee and would investigate with the Senior Leadership Team and report back to this committee if this should be changed and included within the Performance Report. Martin Black noted surprise that there is no statistics regarding the impact that alcohol and drugs are having on A&E Department. Fiona McKay acknowledged that drug and alcohol will impact on waiting times but the information available did not go into detail but noted that the Medication Assisted Treatment (MAT) Standards have now come into force and will investigate with Nicky Connor, Chair of ADP how information could be brought into the Performance Report Rosemary Liewald queried with regards the STAR Team and the expected length of stay within a STAR Bed which is 42 days but in reality, this is closer to 130 days on average before a support package can be put in place which is having a significant impact going forward. She asked how the progress for recruiting staff for the service was going. Fiona McKay advised that there is a rolling recruitment in place to bring more staff on board, in addition there has been a review of care packages to ensure that the care being provided is required and it is hoped that the next report will show an improvement in the figures. Rosemary Liewald queried whether there was flexibility within the service to move people to the private sector. Fiona McKay advised that the budget is aligned to the number of people we have in care and it is managed around the number of beds that are available. She noted that the service is looking at transformation with the philosophy of Home First as the Care Homes are also finding recruitment to be challenging, and there is an impact for the Partnership if the Nursing Home is not able to recruit the registered staff that they need to remain classified as a Nursing Home.	**FMcK**

	David Alexander queried how the ongoing pandemic is affecting the care homes with the current increase in infections. Fiona McKay advised that there is currently 13 care homes closed due to covid but during the height of the pandemic this had been over 30 which had been extremely challenging for the service. Fiona noted that the Public Health Team is working with the service to keep as much of the care home open as possible and advised that the 4th vaccine is soon to be offered to all care home residents within Fife. David Graham thanked Fiona for the report and confirmed that the committee agreed with the recommendations outlined in the report.	
8.	**GRANTS TO VOLUNTARY ORGANISATIONS** David Graham confirmed that this report on grants to Voluntary Organisations is tabled at this committee on an annual basis. Fiona McKay advised that the grants to Voluntary Organisations is devolved to Fife Council's Voluntary Sector Task Group which includes representatives from each of the Councils Services, which includes the Health & Social Care Partnership who award grants to voluntary organisations. Fiona advised as part of the assurance and scrutiny the Link Officer supports the organisations and are involved in recruitment of senior roles for the charities when appropriate. Fiona advised that the voluntary organisations have received an uplift due to the increase in living wage to guarantee that anyone delivering care receives and hourly rate of £10.50 per hour. Fiona wished to assure the committee that she had reviewed all the organisations listed and was satisfied that the report tabled is what was needed for the ongoing commitment for 1 year noting that previously the Service Level Agreements had been in place for 3 years which had been more challenging to agree funding for that length of time. David Graham asked if there were KPI's in place with a requirement for the voluntary organisations to prove that they are meeting their obligations. Fiona advised that in addition to the annual monitoring the link workers attended Board Meetings who raise early indicators if there are any issues. Fiona noted that the Link Officer is swapped in Year 3 when the more detailed report is completed to ensure there is no partiality. Arlene Wood queried with regards the responsibility for assurance around best value and asked if there was any evidence that can be provided from the voluntary organisations listed in Appendix 1. Arlene also asked if additional funding and information was provided specifically for areas of known deprivation to reduce inequalities. Fiona noted that Jackie Stringer has recently commenced role and will be undertaken a strategic needs assessment for the Strategic Plan and will be linking with the Link Officers but noted that it will be challenging to break the support provided down into localities. Fiona confirmed that best values is part of the Service Level Agreement that all organisations are required to sign. Martin Black queried what happens when a voluntary organisation changes their name mid service level agreement. Fiona confirmed that when this occurs staff must transfer over on the same terms and conditions and the new organisations is required to resubmit a revised service level agreement to ensure that they still meet the requirements of the original agreement.	

	Martin Black noted concern with additional fuel and energy costs for voluntary organisations and queried whether this had been taken into consideration. Fiona advised that it is acknowledged that there will be higher costs for those who provide transport via minibuses as fewer people are allowed in the vehicle at one time therefore additional runs will be required. David Alexander advised that money will be made available to support day trips for both young and older people, but the detail is still being worked out. David Graham confirmed with the committee that they were happy to approve the spends associated with the voluntary organisations.	
9.	**TRANSFORMATION AND CHANGE UPDATE** Audrey Valente advised that the associated papers issued with the agenda provided an update on all transformation projects currently being undertaken within the Partnership. She advised that the first Transformation Board took place on 24th January 2022. Audrey advised that the majority of the transformation project dashboards are scored green except for Care Home Replacement and Primary Care Improvement. Audrey advised that the Senior Leadership Team is aware of the issues and a solution has been found to provide additional funding resources for the Primary Care Improvement. Audrey advised that recruitment for the Transformation Team is progressing, but a lot of work has been put in place with the existing team to provide the assurance that governance is in place. Arlene Wood noted that it was exciting to see all the projects and queried whether the review of the Strategic Plan which was highlighted at the last IJB would impact on the pace of the projects going forward. Audrey confirmed that there was a lot happening and the revision of the Strategic Plan being undertaken by Fiona McKay will influence projects going forward. She confirmed that all project, to keep the pace moving, have deadlines set for 30/60 and 90 days going forward. Arlene also noted that within the Membership outlined within the Terms of Reference that there is currently no service user, or third sector member included. Audrey advised that the Transformation is a Strategic Board with a Programme and Project Board sitting below. The Transformation Board will present reports that include progress updates which will then be tabled at the IJB which does have third sector members. Rosemary Liewald noted that there was a lot of acronyms within the dashboards which are difficult to follow and queried the timeframes outlined. Audrey advised that the documentation being utilised by the team were standard templates and would highlight the confusion that acronyms can cause to the Transformation Team. With regards the timeframe it was agreed that further discussion out with the meeting would be beneficial. Martin Black noted that there seem to be an excessive number of members for the Transformation Board and queried whether there was the requirement to have everyone there. Audrey Valente advised that the membership list would be reviewed. David Graham thanked Audrey for the report and confirmed with all that the recommendations had been accepted.	
10.	**COMPLAINTS UPDATE**	

	Audrey Valente advised the report provides an overview of the complaints closed by the Fife Health and Social Care Partnership during the period January to December 2021. During this time there had been 414 complaints closed, 176 closed by Social Care, 1 closed by Fife IJB and 237 closed by NHS Fife. In addition, the Partnership received 310 compliments during 2021. David Graham noted that the service learns from receiving complaints and compliments and noted the importance of sharing the positive comments received with staff. He asked going forward if this report could be renamed to Complaints and Compliments Update. Martin Black queried how the complaints were logged and whether there could be complaints counted more than once if they involved both partnering bodies? David Graham confirmed that within the Health Board the complaints were logged in DATIX and within the Council they were logged in Lagan. Fiona McKay noted that if the complaint spanned both partner organisations then there was the possibility that it is logged within both systems with the complainant receiving separate responses from the Health Board and Council, as the Council would not respond on behalf of the health board and vice versa. Rosemary Liewald noted that themes are looked at but queried whether localities and demographic structure were ever taken into consideration when looking at the complaints received. Audrey advised that currently there is not the staffing resource to undertake this but noted that it is hoped that additional support for the Compliance Officer is being sourced therefore going forward this may be an option to include within the report. Arlene Wood queried who is responsible for dissemination of learning following complaints/SPSO reports received. Fiona McKay noted that this would be included within the Quality Assurance Report and that outcomes and action plans in response to SPSO reports would be reported through the Head of Service onto the Quality Matters Committee and Clinical & Care Governance Committee. David Graham thanked Audrey for the report and confirmed that the report had been brought to the awareness of the committee.	
11.	**ITEMS FOR ESCALATION** It was agreed to escalate the Contributions to the Voluntary Organisations to highlight the significant investment of £10M	
12.	**AOCB** No other issues were raised under AOCB.	
13.	**DATE OF NEXT MEETING:** 29 April 2022 at 2pm via MS Teams	

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE FINANCE & PERFORMANCE COMMITTEE

FRIDAY 29 APRIL 2022 AT 2 PM VIA MICROSOFT TEAMS

Present:
Cllr David Graham [Chair]
Martin Black, NHS Board Member
Cllr Rosemary Liewald
Arlene Wood, NHS Board Member

Attending:
Nicky Connor, Director of Health & Social Care
Fiona McKay, Head of Strategic Planning, Performance & Commissioning
Audrey Valente, Chief Finance Officer
Lynne Garvey, Head of Community Care Services
Norma Aitken, Head of Corporate Service, Fife H&SCP
Euan Reid, Lead Pharmacist Medicines Management

In attendance:
Karen Nisbet, Team Manager (For Section 6)
Carol Notman, Personal Assistant (Minutes)

Apologies for Absence:
Cllr David Alexander
Rona Laskowski, Head of Critical and Complex Care Services
Helen Hellewell, Associate Medical Director

		ACTION
1.	**WELCOME AND APOLOGIES** David welcomed everyone to the Finance & Performance Committee and apologies were noted (see above).	
2.	**DECLARATIONS OF INTEREST** There were no declarations of interest noted.	
3.	**MINUTE OF PREVIOUS MEETINGS – 11 MARCH 2022** Arlene Woods noted that she had a few amendments to the minutes and would contact Carol Notman out with meeting to discuss. Martin Black queried when there would be an update on the impact that alcohol and drugs were having within the A&E Department. Fiona McKay advised that this information would be reported as part of the HEAT Targets and would be included within future performance report.	CN/AW

4.	**MATTERS ARISING / ACTION LOG** Arlene Wood queried why a previous outstanding audit recommendation was no longer noted within the action log. Audrey Valente confirmed that this had been discussed at the IJB and it had been agreed that it would be more appropriate for the item to be tabled at the Audit and Risk Committee.	
5.	**RECORD MANAGEMENT ANNUAL REPORT** Audrey Valente advised that the Public Records (Scotland) Act 2011 requires named authorities, including Fife Integration Joint Board, to prepare and implement a Records Management Plan to set out proper arrangements for the management of its records. Audrey advised that the Keeper's Assessment of the Record Management Plan for the IJB was very positive with 10 Green, 4 Amber and 0 Red. Audrey confirmed that the IJB Action Plan 2019-24 includes activities that will progress the four amber elements to a green status whilst maintaining the positive performance already achieved in other areas. Martin Black noted that the report was very good and queried what happens when the amber elements progressed to green. Audrey confirmed that the IJB would always strive for continuous improvement. David Graham thanked Audrey for the report and confirmed that the report had been discussed in line with the recommendations outlined within the report.	
6.	**TRANSITION OF YOUNG PEOPLE TO ADULT SOCIAL CARE ARRANGEMENTS** Audrey Valente introduced the report advising that it was the requested updated report regarding the transfer of young people leaving school entering the adult social care services, highlighting the pressures for both the young person and their family as well as the Partnership. Audrey advised that work is ongoing with Fife Council to get a 3-year forecast but it is acknowledged that this is subject to fluctuation therefore the service will review the situation on a 6-monthly basis. This report reflects the first iteration of this forecast which estimates the full year costs to be circa £600,000 and confirmed that the IJB had approved this funding. David Graham noted that the packages involved have significant costs associated to them and queried whether regular updates would be tabled at this committee to monitor the costs. Audrey confirmed that this was the plan. Rosemary Liewald advised that the forward planning outlined within the report would be welcomed by the young people involved who are making the transition and their families. David Graham confirmed that the report had been brought to the attention of the committee as per the recommendation outlined within the document.	
7.	**RETRACTION PLAN** Lynne Garvey advised that the retraction plan had been brought to the committee for awareness and to give assurance that the Partnership has continued to provide the most critical needs during the pandemic. Lynne advised that the HSCP had embedded a whole system response approach to escalating pressures and demands and had introduced the Operational Pressures Escalation Level tool (OPEL) which had brought a	

	consistent approach, improved management of system-wide escalation, and ensured wider cooperation and oversight across the whole HSCP. Lynne advised that the Opel Scores had been reducing from March, with a slight increase in the last few weeks which has allowed the retraction of services and the majority of deployed staff to be returned to their substantive role. Lynne wished to highlight for assurance purposes that the Partnership did not stop a service throughout the pandemic, business has been as usual but not as optimal as it would have been prior to the pandemic. Lynne noted that the appendix supplied a comprehensive plan and update from every service. David Graham noted that he was contacted regularly by his constituents regarding access to adult services and noted that although the staff have been remobilised back there are still a significant number of vacancies within the service therefore the service is still experiencing staffing pressures. Lynne confirmed that the service was looking to fill the vacancies as quickly as possible. Arlene Wood noted that the Escalation Policy is excellent but wished to confirm why there would be no positive impact from cost avoidance. Lynne advised that as the Service had to surge so many beds during the pandemic due to wards/care homes being closed which had incurred significant costs which had been aligned therefore the service had not experienced cost pressures. Lynne confirmed that these additional costs for surge beds had been aligned appropriately to either Covid or Winter monies. Audrey Valente confirmed that the funding was being investigated as the service had incurred additional costs and was required to deliver within the budget envelope that was available. Martin Black noted concern with the retraction plan in place and restrictions being lifted it appears as if everyone is saying that the pandemic is over, he acknowledged that while covid infections were reducing the impact was still ongoing and significantly affecting services. Martin queried whether the Partnership was looking to the international market to attract additional staff to support services. Lynne advised that Lynn Barker has confirmed that there are currently 4 international nurses identified to work within the community hospital and she looked forward to welcoming them into their new roles. David Graham confirmed that the report had been brought to the awareness of the committee for information as outlined within the recommendations.	
8.	**REMOBILISATION OF THIRD SECTOR** Fiona McKay advised over the last two years many of the day services across the third sector had been closed due to the difficulties with social distancing and capacity within buildings when often these are local buildings and not purpose built. She advised that the Link Officers have been working with the organisations helping them to diversify where possible to support people in their own homes with befriending or online chats. The Appendix outlines the availability within the Third Sector highlighting the changes in availability pre and post covid. Fiona advised that some had required to reduce their placements due to the size of their buildings.	

	Fiona advised that the Partnership has engaged with new organisations such as Careology in Kirkcaldy who provide specific day services for older adults and their carers. David Graham queried the number of organisations that receive funding support from the Partnership. Fiona McKay confirmed that they all received the grant that was made available to them and acknowledged that there has been difficulties if staff have been furloughed or made redundant and confirmed as part of the re-organisation the Partnership will be reviewing the funding received in accordance with current placement availability. Martin Black queried whether the service is applying the pre-lifting of restrictions criteria and asked if risk assessments had been carried out to allow more people into the premises. Fiona McKay confirmed that Public Health have undertaken a risk assessment for all premises and while the 1m distancing guidance is in place some organisations have looked at splitting their day to allow for more engagement. Fiona confirmed that a review of services will be undertaken in July to ensure that there is best value across the whole system with some traditional services being changed to new services such as befriending and gardening clubs which have emerged during the pandemic. David Graham acknowledged the huge amount of work that has been undertaken by the voluntary sector over the last 2 years and confirmed with the committee that they were happy to accept the recommendation outlined within the report.	
9.	**ITEMS FOR ESCALATION** No items were identified for escalation.	
10.	**AOCB** Nicky Connor wished to thank David Graham for his chairing of the Committee over the last 5 years and to the contribution that both he and Rosemary had given to the IJB and Partnership over the years and wished them well in the upcoming elections. David Graham wished to thank the Officers for their support over the last 5 years. Nicky Connor advised that this was the last Finance & Performance Committee as going forward it would become the Finance, Performance & Scrutiny Committee.	
11.	**DATE OF NEXT MEETING:** 8 July 2022 at 10.00am via MS Teams	

Fiona McKay
HSCP Head of Strategic Planning, Performance & Commissioning
6th Floor West, Fife House, Glenrothes

REPORT OF THE PHARMACY PRACTICES COMMITTEE HEARING HELD ON MONDAY 30TH MAY, 2022 AT 09.30 AM VIA MICROSOFT TEAMS

Present:

Appointed by NHS Fife

Mr Martin Black (Chair)
Mr Arthur Andrews, Lay Member
Ms Sandra Auld, Lay Member

Nominated by Fife Area Pharmaceutical Committee

Mr Raymond Kelly, Contractor Pharmacist nominated by the APC
Mrs Cara MacKenzie, Non-Contractor Pharmacist nominated by the APC

In Attendance:

Mrs Joyce Kelly, Primary Care Manager, Primary and Preventative Care, FHSCP, Note Taker
Mrs Karen Brewster, Note Taker
Miss Dianne Watson, Note Taker

INTRODUCTION/BACKGROUND

APPLICATION FOR INCLUSION IN NHS FIFE'S PHARMACEUTICAL LIST

The hearing was called to consider an application submitted by Mr Mohmmed Ameen to provide General Pharmaceutical Services from premises situated within 94 High Street, Burntisland, Fife, KY3 9AS

Under Regulation 5(10) of the NHS (Pharmaceutical Services) (Scotland) Regulations 2009, as amended ("The Regulations") the Pharmacy Practices Committee (PPC) were required to determine whether the granting of the application was necessary or desirable to secure the adequate provision of Pharmaceutical Services in the neighbourhood in which the Applicant's proposed premises were located.

a) The Regulations require that the Committee shall have regard to:-

- the Pharmaceutical Services already provided in the neighbourhood of the premises named in the application by persons whose names are included in NHS Fife's Pharmaceutical List;
- any representations received by the Board under paragraph 1 of the aforementioned Regulations;
- any information available to the Committee which, in its opinion, is relevant to the consideration of the application;

- the Consultation Analysis Report submitted in accordance with regulation 5A;

- the Pharmaceutical Care Services Report; and

- the likely long term sustainability of the Pharmaceutical Services to be provided by the Applicant.

b) It was noted that copies of the following had been supplied to the members of the Committee, the Applicant and those who submitted a representation and had accepted the invitation to attend the hearing.

- Application Form A (1),
- Letter from Councillor Gordon Langlands
- Letter from Councillor Lesley Backhouse
- Letter from Councillor Kathleen Leslie
- Burntisland Community Action Plan
- Proposed Layout of Pharmacy
- Newspaper Article – Why Burntisland High Street is booming
- Newspaper Article – This NHS Fife Town is thriving while others struggle – here's why

- Representations received from ;-

I. Royal Burgh of Burntisland Community Council
II. Lloyds Pharmacy
III. Omnicare Pharmacy
IV. NHS Fife's Area Pharmaceutical Committee

- Consultation Analysis Report (CAR)

- A map of the area indicating the location of the proposed Pharmacy, existing Pharmacies and GP Surgeries and distances from these to the proposed site.

- An extract from the Fife Local Development Plan

- PPC Rules of Procedure

- Pharmaceutical Services Report 2019/20

c) The Chair determined that the hearing should take the form of an oral hearing and the Applicant and those who submitted a representation were given the opportunity to attend the hearing. Those who accepted the invitation are listed below:-

i. Mr Mohammed Ameen, Applicant
ii. Mr Tony O'Reilly, Lloyds Pharmacy
iii. Mr Chris Freeland, Omnicare Pharmacy
iv. Mrs Carol Rogers, Community Council Representative

d) The Committee noted that written notification of the application from Mr Ameen was issued to the under-noted within 10 working days of the application being received in accordance with paragraph 1 of schedule 3 of the Regulations:-

i. NHS Fife's Area Pharmaceutical Committee
ii. NHS Fife's GP Sub Committee
iii. Pharmacies in Burntisland, Aberdour and Kinghorn
iv. Local Community Council

It was also noted that the Application had been provided to NHS Fife's Director of Pharmacy.

e) The Committee noted that written representations were received from the under noted within the required 30 days of written notice being sent to them:-

i. Lloyds Pharmacy
ii. Omnicare Pharmacy
iii. Royal Burgh of Burntisland, Community Council Representative
iv. NHS Fife's Area Pharmaceutical Committee

No.

01/22 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the hearing, and round the table introductions were made.

02/22 DECLARATION OF MEMBERS INTERESTS

Prior to the commencement of the hearing, the Chair asked the members whether any of them had an interest to declare or were associated with a person who has any personal interest. The Chair then asked the Applicant and interested parties whether any person assisting them at the hearing was appearing in the capacity of Counsel, Solicitor or paid Advocate.

The Chair asked those present if they had any objections to the meeting being recorded for the purpose of the Minutes. All those present agreed they had no objections to the meeting being recorded.

There were no other declarations of interest, nor were any persons making representation attending in the capacity of Counsel, Solicitor or paid Advocate.

03/22 FORMAT OF HEARING

The Chair briefed those in attendance of the intended format of the hearing.

The Chair advised that the Applicant would be asked to make his submissions, followed by questions from the interested parties, then from members of the Committee.

The interested parties would then be asked, in turn, to make their submission, followed by questions from the Applicant, the other interested parties and then the Committee.

The interested parties would then be given the opportunity to sum up, followed by the Applicant.

04/22 APPLICANT'S ORAL SUBMISSION

Mr Ameen thanked everyone for attending to discuss and consider his application to open a

new Pharmacy from premises situated within 94 High Street, Burntisland, Fife, KY3 9AS.

Mr Ameen (MA) spoke to his Presentation (Attached as Appendix 1)

05/22 INTERESTED PARTIES QUESTION THE APPLICANT

05/22.1 Mr Christopher Freeman questioned Mr Ameen (MA)

CF asked why MA felt it was important to have two pharmacists within a pharmacy that dispenses less items.

MA believed this went back to 2008 then followed on in 2016 when Lloyds Pharmacy themselves proposed employing an additional pharmacist to alleviate the pressures. Lloyds put this specific solution in place then removed the pharmacists twice.

CF asked MA if he felt the situation had changed recently in terms of there being less pharmacists available now in Scotland than there was in 2016.

MA did not believe this was the case and had no knowledge of this.

CF did not agree as Omnicare branch in Leven has had a shortage of pharmacists for under a year and has had no applicants. He believed pharmacists have had to adapt due to the lack of pharmacists and felt the use of ACTs has been important and asked MA if he would agree that a pharmacy could run with a pharmacist and one or two ACTs.

MA was confident that there was not a deficit of pharmacists within the community pharmacy sector, he went on to say that he knew of a huge exodus of pharmacists that are leaving pharmacy manager positions and becoming locums, which he believed has been the case over the last few years. He felt the Covid pandemic had exacerbated the situation and believed this is the reason for the lack of pharmacists in the Omnicare branch.

CF asked MA if he was of the opinion that the opening hours of the existing pharmacy are adequate.

MA believed Lloyds Pharmacy in Burntisland cover the model hours and even go a step further, which is reflective of the hours the proposed pharmacy also wish to cover.

CF asked if he would be offering the same hours with no increase in hours.

MA confirmed that the new pharmacy would not cover hours over and above the proposed hours. He reported that in the CAR, the vast number of people had said the hours were satisfactory with a few who had mentioned extended opening times. He would be happy to look into this once the core provision and the proposed opening hours have been provided.

CF asked MA if he agreed that many of the population of Burntisland work outwith the area and would access pharmaceutical services where they work.

MA agreed a small percentage would, but reported that the Pharmaceutical Care Plan states that almost 90% of the population would access pharmaceutical services within their home town and believed that Burntisland community would follow that same protocol.

CF asked if there is a secondary school in Burntisland.

MA was unsure but did not believe so.

CF presumed that residents would then need to travel outwith Burntisland to attend the secondary school.

MA agreed but also reported that there is a vast amount of amenities within the Burntisland neighbourhood and that most people would access pharmacy services within their own neighbourhood.

CF stated that in the applicant's documentation he had read that people have been loitering outside the existing pharmacy and asked, in terms of the proposed pharmacy, how that would alleviate the pressure on Lloyds Pharmacy if it was smaller.

MA reported that the proposed pharmacy will be approximately 84 square metres which is a substantial size.

CF asked if MA will be offering supervised Methadone or Buprenorphine to drug misuse patients.

MA confirmed he would not.

CF stated that according to the CAR this was a service the proposed pharmacy was going to be providing and asked MA to confirm.

MA did not believe this was the case and stated that Methadone seems to be a problem, particularly around the area in which Lloyds Pharmacy is situated. MA's proposal is not to get involved in this service and he confirmed that the proposal is designed to alleviate the pressure on core services that Lloyds Pharmacy provides, which will allow Lloyds to focus on the additional services so they can provide a better service and help with social mismanagement. The fact that the pharmacy will be in the west end and further away from the existing pharmacy, will potentially spread the traffic flow and make the west end busier. He believed the biggest concerns raised in the CAR was lack of core service provision. In his opinion, indirectly the new pharmacy will alleviate the pressure on the Methadone Service.

CF asked if MA was aware of any complaints to the Health Board regarding pharmacy services in Burntisland.

MA believed that the CAR was an ode of complaints. Long waiting times being mentioned 327 times, which he felt was more or less complaints and indicated that this document is managed by the Health Board.

CF asked, looking at other applications that the applicant had submitted elsewhere, what the percentage of the response rate had been to the CAR compared to this application.

MA believed that the response rate for Burntisland CAR had been phenomenal, and compared to Pumpherston and Townhill, about the same response.

CF reported that he was at the Pumpherston Hearing and believed it was about a 20% response, where Burntisland is only about 7% which is significantly lower, which shows the residents of Burntisland have no issues with the existing pharmacy services and asked MA if

he agreed this is the case.

MA referred CF to a slide which showed the Sample Size per Margin of Error in a questionnaire, to which there were 450 responses. This showed that people said there was a lack of pharmacy provision.

CF still felt this was a low response compared to other applications.

MA pointed out that the areas were different sizes of populations.

CF stated that Aberdour Pharmacy had doubled the number of prescriptions due to their Care Homes and asked MA if he thought people from Burntisland were using Aberdour Pharmacy.

MA did not believe they were as it was 3.2 miles away and no one would be able to walk to it, which he felt was reflected in the CAR.

CF asked if MA agreed that people are not accessing services in Aberdour Pharmacy as they feel that the pharmacy services in Burntisland are adequate.

MA referred back to the CAR which showed that the current provision of pharmaceutical services is inadequate due to long waiting times accessing medicines due to the restrictions from suppliers.

CF asked if MA agreed the pandemic has emphasized the issue with waiting times all over.

MA reported that the vast number of respondents to the CAR and the Community Council are referring to a timeline which is pre Covid, although there may have been extended waiting times before Covid but it refers specifically to this long standing set of issues.

05/22.2 Mr Tony O'Reilly (TO) questioned Mr Ameen (MA)

TO asked MA, if his application was to be successful how many pharmacists he would have in the premises.

MA confirmed there would be one full time pharmacist.

TO asked why MA considered that other pharmacies should have two pharmacists.

MA confirmed that he does not consider this, and stated that this is due to the proposals and solutions that Lloyds Pharmacy have put forward over the last 15 years to the various PPCs.

TO was concerned that MA was a little out of touch, in terms of the workforce situation in Community Pharmacy at the moment having a shortage of pharmacists. He asked MA if he was aware that Community Pharmacists are on the short occupation list.

MA was not aware of this. He believed there was a movement of pharmacists going to GP Practices and hospitals and believed that in his experience the biggest factor was that pharmacy managers were making the move from manager positions to locums.

TO asked MA if he was aware of how many pharmacists have left community pharmacy to go to Primary Care in terms of GP Practice based pharmacists.

MA did not know.

TO asked MA if he was also aware, around the number of vacancies for pharmacists being at an all time high.

MA believed that there was a restructuring of pharmacists not necessarily a deficit.

TO asked if MA could tell him the number of staff Lloyds Pharmacy has now as MA had eluded to the fact their numbers had decreased.

MA stated that the commitment that Lloyds Pharmacy had put forward at each PPC Hearing was that they would add in an extra pharmacist, who would cover three days per week, and once the second pharmacist had become unsuccessful that second pharmacist was removed. Also in the 2008 application there had been a proposal to increase staff levels by 38 hours, which happened for a brief period but was then removed and most recently there has been a restructuring of Lloyds to cut back on non-pharmacist staff, which he believed was in the region of 40 hours per week.

TO asked how many hours of staffing Lloyds have in the current pharmacy compared to back then.

MA believed that there was no doubt that TO would elevate his numbers due to the current application.

TO denied this and believed that MA was second guessing. He confirmed that they had invested in Lloyds Pharmacy in Burntisland and also brought in an ACT who can check prescriptions to alleviate the pressure on the pharmacist and the hours have increased.

MA pointed out that it was clearly stated in the statement of the elected Community Council that there were long waiting times.

In terms of waiting times TO asked if MA believed that Covid had an impact on pharmaceutical services in every town and Community Pharmacy in Scotland.

MA reiterated that comments made by residents and the community council regarding long waiting times were pre Covid.

TO asked MA what he felt was inadequate in terms of Lloyds Pharmacy in Burntisland.

MA believed the lack of core services being provided consistently by Lloyds Pharmacy was inadequate.

TO asked MA what services Lloyds Pharmacy do not provide.

MA was of the opinion that Lloyds Pharmacy do not provide the core services at an adequate level.

TO confirmed that Lloyds Pharmacy provide all core services and additional services to an adequate level. This includes Pharmacy First, Dossett Boxes, free delivery. He asked what was MA's reasoning for thinking Lloyds Pharmacy were providing an inadequate service.

MA stated that the evidence was in the CAR.

TO stated that less than 6% of the population of Burntisland were in support of his application.

MA addressed the Chair and asked that TO asked questions only and not state facts. The Chair agreed.

TO believed there was more than one pharmacy in the High Street in Burntisland, the other being Dears Pharmacy next door, which furnished prescriptions and asked MA to confirm.

MA reported that there was only one pharmacy as Dears was not a pharmacy but a Health and Beauty store which caters for the wider network.

The Chair asked Joyce Kelly (JK) for clarification on this.

JK confirmed that Dears do not have a pharmaceutical contract in Burntisland, it is a Health and Beauty store. They have a locker box on the outside of their premises where people can drop their prescriptions, which are then taken to one of their pharmacies who do have a contract to be dispensed, then brought back to the locker box to be collected at people's own leisure.

MA wanted to add that pharmaceutical services are not offered from the Health and Beauty store, but he believed they provided this service as they have known that Burntisland suffers from critical issues, namely that it is difficult to access to a pharmacy timeously to have their prescriptions dispensed. He believed that this service is to help alleviate the issues in Burntisland.

TO asked how MA felt that a patient with a pharmaceutical need, as in Methadone, is going to be denied treatment from them.

MA confirmed that there was no denial but reiterated that his proposal was based on core provision for the vast majority of people. He stated that the Methadone service is an additional service and believes the new pharmacy could help alleviate pressures on the existing pharmacy, by providing the core services. He reported that, by opening a new pharmacy, he did not want to replicate the social disorder and felt that one methadone supplier was sufficient in Burntisland.

TO asked if there was any additional housing in Burntisland and if so how many.

MA confirmed there is additional housing but did not have the information to hand.

06/22 COMMITTEE MEMBERS QUESTION THE APPLICANT

06/22.1 Questions from Mr Arthur Andrews (AA) to the Applicant (MA)

AA had no questions for MA.

06/22.2 Questions from Mrs Carol Rogers (CR) to the Applicant (MA)

CR had no questions for MA.

06/22.3 Questions from Ms Sandra Auld (SA) to the Applicant (MA)

From a service user point of view, SA asked how likely it would be that the proposed pharmacy would open after 6pm, even one night per week.

MA confirmed that the new pharmacy will not initially, but they will be opening at 8.30am to capture GP appointments at that time. He is more than happy to look into an audit regarding extended opening hours if there is a need for people who are perhaps working beyond the specified hours if the application is granted.

06/22.4 Questions from Mr Ray Kelly (RK) to the Applicant (MA).

RK asked MA what the population of the neighbourhood in which the pharmacy will be servicing was.

MA confirmed that the population of Burntisland is 6,620.

RK asked if MA knew what the average population would be for one pharmacy in Scotland.

MA did not know.

RK asked if MA was aware of any other areas across Scotland that had a smaller population than 6,620 that have no pharmacy.

MA confirmed that Pitlochry has a population of about 2,800 and has two pharmacies.

RK asked if MA would accept that Pitlochry has a level of tourism population.

MA accepted this.

RK asked if a second pharmacist is a legal requirement for a pharmacy.

MA confirmed that it is not but stressed that this was raised by Lloyds Pharmacy in the 2008 application to the PPC.

RK asked if it is possible that if Lloyds Pharmacy was better managed, this would resolve their problems.

MA reiterated that Lloyds had made proposals and commitments in 2008 and again in 2016 which they had reneged upon a second time. He believed explicitly that they would still not be able to offer a consistent level of adequate service as the solutions they put forward are short term whereas the solutions MA are putting forward are long term solutions of providing a consistent adequate pharmacy service.

RK asked if he knew of any formal complaints that have been submitted to NHS Fife regarding Lloyds Pharmacy.

MA shared a slide which showed the catalogue of complaints submitted to NHS Fife regarding Lloyds Pharmacy from January 2019 to March 2022 which was included in the CAR.

RK asked MA to clarify his comment regarding the CAR being run by the Health Board.

MA clarified that the CAR was a joint process between the applicant and the Board, but confirmed that the Board takes the lead on this.

RK asked him to clarify that this was the standard process that is usually followed.

MA agreed.

RK asked if, according to the SIMD data, it is the two zones of Burntisland that fall into the red zone which are Burntisland Docks and Burntisland Links.

MA shared a slide “Burntisland Health Comparison” showing that Burntisland sits in the 15% most deprived for health compared to Aberdour and Kinghorn.

RK asked MA to confirm that Aberdour, Kinghorn and the surrounding areas did not fall into the proposed neighbourhood.

MA confirmed they did not. This was for information and comparison on the health challenges to other areas within the Burntisland neighbourhood.

RK was surprised that Methadone would not be provided if the new contract was granted. He was curious to know if Methadone patients would be in the top or the bottom 15%, where Methadone would be more relevant to these patients.

MA did not think this was about not providing Methadone but in fact this application was about offering the other core services that this population was devoid of. Methadone is an additional service that Lloyds Pharmacy is offering, and he felt it was crucial, within the community, that they should be able to address it single handed.

RK then asked MA if he agreed that the pharmaceutical service for Methadone in Burntisland is adequate, and this being the reason he did not feel the need to offer that service.

MA reiterated that his remit is about core services only and Methadone is not a core service.

RK asked if MA realised that although the new pharmacy would open from 8.30am to 5.30pm the Board could not enforce these hours or to open on a Sunday, therefore if the contract was awarded he could then reduce his hours to the core hours.

MA was aware of this.

The Chair asked Ms Sandra Auld (SA) if she had a question.

SA asked if the slide that MA shared was an amalgamation of complaints from different sources.

MA explained that this was part of a freedom of information request that he had submitted to NHS Fife regarding the official complaints that are submitted to them.

SA thanked MA for the clarification and reported that when she had gone to the site visit she had spoken to about 12 people and of those there were two people specifically who had changed where they obtained their prescriptions from which was Lloyds Pharmacy to Dears as they were unhappy with the provision.

06/22.5 Questions from Mrs Cara MacKenzie (CM) to the Applicant (MA)

CM asked MA how he would staff the new pharmacy.

MA confirmed there will be a full time pharmacist, two dispensers and a counter assistant in the first 12 month period then he will take stock of the situation thereafter.

CM asked MA to confirm that the new pharmacy would not be providing Methadone as Lloyds Pharmacy currently provides this service.

MA confirmed this is the case. He believed that the new pharmacy would alleviate the pressure on Lloyds Pharmacy so they can concentrate on the additional services like Methadone provision. He felt it was important to note that the social disorder that has been created by Lloyds has become so bad that it has been escalated to Holyrood.

The Chair intervened to say he felt uncomfortable with the statement MA had made regarding Lloyds Pharmacy creating social disorder as in his opinion a pharmacy did not create social disorder.

Tony O'Reilly agreed with the Chair's statement. He believed the social problem exists in the neighbourhood and the service Lloyds are providing is helping to cater for that social problem. He felt it was a rather harsh and incorrect statement to make.

MA asked if he could clarify his statement. He believed there is certainly a need for substance misuse services within the area, which has not been created by Lloyds, but what has been created by Lloyds is the mismanagement of the service, therefore mismanagement spills onto the streets daily, which makes Lloyds Pharmacy responsible for some of the social disorder.

RK asked MA to clarify what he meant by social disorder, which he felt was an uncomfortable term.

MA reported that the CAR acknowledged social disorder. A number of the Community Councils that MA has attended also echo this. This is mostly caused by the long queuing system and long waiting times whilst people are waiting to access the pharmacy for various services i.e. prescriptions, Methadone. He felt that when substance misusers are being forced to queue, this causes social disorder.

CM asked MA, regarding Methadone dispensing, if he believed it would be possible for Lloyds to serve the population of 6,000 or 7,000 along with their other prescriptions and the core services.

MA was of the opinion that Lloyds have proven over the last 15 years that they have not been able to do that.

CM asked if he thought this would be possible if this had been another pharmacy rather than Lloyds.

MA felt that Lloyds Pharmacy do not have the capacity to deal with this situation. He stressed that he had never seen a community that had to deal with these long standing issues, e.g. Applications submitted, solutions put in place then removed. He believed the only solution was to grant a new pharmacy, due to the fact that Lloyds have tried in the past, but it is never a long term solution.

CM asked MA if he felt it was reasonable to accept that one community pharmacy could

serve that amount of the population, taking Lloyds out of the equation.

MA believed one pharmacy could serve this amount of the population, if taking Lloyds out of the equation.

06/22.6 Questions from the Chair (Ch) to the Applicant (MA)

Ch asked MA if the letter of support from Councillor Gordon Langlands was contingent on the new pharmacy not providing Methadone and if this would be withdrawn if he did provide Methadone. The Councillor also refers to Dears Pharmacy not having a resident pharmacist even though Dears is not a pharmacy. Ch felt Mr Langlands would only be supportive of the application if MA agreed with him which did not sit well with the Ch. He also pointed out that MA had made a statement that the provision of the Methadone service in Burntisland was adequate but then said it was inadequate as it is causing issues. Ch had studied the CAR and found in most cases there was support for a new pharmacy but he believed it was about the inefficiency as opposed to the inadequacy of provision is what people are eluding. He felt Methadone was mentioned a great deal and he was not convinced this was about inadequacy or inefficiency. He asked MA how he would go about changing his perception.

MA believed that Councillor Langland's letter regarding Dears being a pharmacy was a source of confusion. He had attended a local council meeting and spoke to one of the Councillors, who's mother did not know how to use the locker box outside Dears Health and Beauty store and as there is no resident pharmacist there was no one to ask for help. He believed there is a level of confusion to whether this is a pharmacy or not. Regarding the inadequate Methadone provision and the inefficient provision, he believes it's the latter. He reiterated that the reason he applied for a contract was about core provision and services that the community is devoid of. He believed there is a small subset of people using Methadone provision and therefore he did not feel people should be focusing too much on this provision especially when it is not a core service. The solution he is putting forward is to allow a new pharmacy to alleviate the pressure on the existing pharmacy to enable it to improve its core services and better improve its additional services such as the Methadone programme.

07/22 INTERESTED PARTIES' ORAL SUBMISSIONS

07/22.1 Mr Chris Freeland (CF) spoke to his presentation. (Attached as Appendix 2)

08/22 INTERESTED PARTIES QUESTION MR FREELAND

08/22.1 Questions from the Applicant (MA)

MA had no questions for CF.

08/22.2 Questions from Mr Tony O'Reilly (TO) to Mr Chris Freeland (CF)

TO asked CF what the waiting times are for Lloyds Pharmacy.

CF confirmed the waiting times are 5 to 10 minutes depending on the prescription, it could be 15 minutes maximum.

TO asked if Lloyds Pharmacy has any staffing issues.

CR confirmed there are currently no staffing issues.

08/22.3 Questions from Mrs Carol Rogers (CR) to Mr Chris Freeland (CF)

CR had no questions for CF.

09/22 COMMITTEE MEMBERS QUESTION MR FREELAND

09/22.1 Questions from Mr Arthur Andrews (AA) to Mr Chris Freeland (CF)

AA asked CF what percentage of prescriptions his pharmacy served to the neighbourhood of Burntisland.

CF confirmed that Omnicare Pharmacy provided a service more to the housebound within Burntisland. Prescriptions are collected and delivered daily to people who cannot access pharmaceutical services. He felt it was a low number of perhaps 5% per month.

09/22.2 Questions from Ms Sandra Auld (SA) to Mr Chris Freeland (CF)

SA asked CF if he said he was creating a prescription pick up for Burntisland or he had already.

CF confirmed they have always picked up prescriptions from the GP Surgery then dispensed them at the pharmacy, then they are either delivered or picked up by the patient.

09/22.3 Questions from Mr Ray Kelly (RK) to Mr Chris Freeland (CF)

RK asked CF if Aberdour would be included in the data zone.

CF did not think it would.

To confirm RK asked if Omnicare Pharmacy was located outwith the neighbourhood as defined by the Applicant.

CF confirmed that Omnicare Pharmacy is situated outwith the neighbourhood.

The Chair asked MA to confirm.

MA confirmed that Aberdour was not covered in the data zone.

RK asked if Omnicare Pharmacy currently provide a Methadone Services.

CF confirmed they do.

RK asked if the Burntisland Surgeries cover the old style CMS.

CF was unsure as he did not visit the pharmacy too often.

RK asked if Omnicare Pharmacy currently suffer from stock shortage.

CF confirmed this was the case and believed most pharmacies do in terms of supply chains.

RK asked what the opening hours currently are in Omnicare Pharmacy in Aberdour.

CF confirmed the pharmacy are open from 9am to 5.30pm, Monday to Friday and 9am to 12.00pm Saturday.

RK asked if they are open over lunch.

CF confirmed they are open over lunch.

09/22.4 Questions from Mrs Cara Mackenzie (CM) to Mr Chris Freeland (CF)

CM asked CF if Omnicare Pharmacy charge for delivery of prescriptions.

CF confirmed they do not charge for delivery.

09/22.5 Questions from the Chair (CH) to Mr Chris Freeland (CF)

Ch asked how many prescriptions Omnicare Pharmacy collect from the Burntisland area. He also asked if CF was aware if the shortage of pharmacists in Fife and in Scotland was evidential or perception.

CF stated that Omnicare have a structure of retaining pharmacists whereas he was aware that other pharmacies across Scotland are struggling due to the movement into Primary Care and Hospitals, which is evidence based. As for the number of prescriptions Omnicare Pharmacy collect from Burntisland, CF confirmed it was in the region of 5% per month.

10/22.1 Mr O'Reilly (TO) spoke to his presentation (Attached as Appendix 3)

INTERESTED PARTIES QUESTION MR O'REILLY

10/22.2 Questions from the Applicant (MA) to Mr Tony O'Reilly (TO)

MA pointed out that TO had mentioned that the Community Council had not interfaced with Lloyds Pharmacy to communicate that there were issues and asked TO if this was correct.

TO stated that from the previous PPC Hearing in 2016, Lloyds asked to either meet with the Community Council or for any feedback and at no time have they had such dialogue from the Community Council.

MA reported that he had attended a number of Community Council meetings over the last 4 or 5 years and on more than one occasion it had been mentioned that Lloyds pharmacy have not engaged with the Community Council. MA had also heard this from the executive members of the Community Council Leadership.

TO reiterated that he had no representation from the Community Council or direct dialogue or feedback from them on any of their service provision.

10/22.3 Questions from Mr Chris Freeland (CF) to Mr Tony O'Reilly (TO)

CF asked TO if Lloyds Pharmacy provide all the core services.

TO confirmed that they do offer all core services.

CF asked if TO was aware of the waiting times for a one to two item prescription.

TO confirmed that waiting times were generally around 10 minutes, unless there is a backlog of prescriptions from the GP Practices, which could have a slight impact on waiting times.

CF asked if the waiting times would be longer if there were more items.

TO confirmed it would be longer, but they try and prioritise on patient need and collect the prescriptions from the practice in advance to decrease waiting times.

CF asked if Lloyds Pharmacy offer a delivery service.

TO confirmed they do provide a delivery service.

CF asked if, during the pandemic, the waiting times were longer reflecting most pharmacies in Scotland.

TO confirmed that this was the case.

CF asked if Lloyds Pharmacy had been closed anytime during the pandemic.

TO confirmed that when the Covid pandemic first came about they closed over lunch for one hour, they also reduced their hours at the start and end of the day in agreement with the Health Board, which was removed over a year ago.

CF asked, if the application was granted, did TO think it would affect the viability of Lloyds Pharmacy.

TO was absolutely sure it would and would also affect their investment in the pharmacy and have a huge impact.

CF asked TO, with a population of this size, if he believed that one pharmacist was enough to provide all the core services and additional services that they provide to the community of Burntisland.

TO believed one pharmacist is adequate for the number of services they provide, which is growing through Pharmacy First, particularly through Methadone and CDS needs and reviewing staffing levels to suit.

In terms of social disorder, which CF believed was a bit extreme, he asked TO if this was a common issue across all pharmacies who provide Methadone.

TO believed it was an issue all over as he had worked in a lot of places and felt this was a social economic issue that pharmacies are faced with but felt that pharmacists have a duty of care to look after that population without discriminating against them. TO believed that it is up to Lloyds Pharmacy to work with the local authorities to look after that population.

10/22.4 Questions from Mrs Carol Roger (CR) to Mr Tony O'Reilly (TO)

CR had no question for TO.

COMMITTEE MEMBERS QUESTION MR O'REILLY

10/22.5 Questions from Mr Arthur Andrews (AA) to Mr Tony O'Reilly (TO)

AA said it was implied earlier that TO was going to open a second pharmacy in Burntisland which has not happened and asked if that is correct.

TO confirmed that was incorrect and added that there is another pharmacy next door.

The Chair interrupted as he was unhappy with Dears Health and Beauty premises being referred to as a pharmacy. He stressed a locker box is not a pharmacy.

The applicant agreed and felt it should be noted that there is only one pharmacy currently serving the population of Burntisland.

AA asked if it was correct that TO had said that if there was a second pharmacy application granted in Burntisland, it would affect the viability of Lloyds Pharmacy.

TO confirmed that this is correct.

AA asked if the difficulty in the chain of suppliers is true for every pharmacy.

TO agreed it would be. He advised that Lloyds Pharmacy have three wholesalers but they are having problems due to Brexit, supplies from Asia and shipping, therefore creating difficulties obtaining drugs into the UK and into pharmacies.

AA asked if the issues around Methadone are a management problem and if the pharmacy is dealing with them.

TO believed this had been blown out of proportion as there had not been any social disorder when he had visited Lloyds Pharmacy in Burntisland. The manager has been there for a number of years and knows the clients well. He did not believe there is a social problem.

10/22.6 Question from Ms Sandra Auld (SA) to Mr Tony O'Reilly (TO)

In relation to some of the comments in the CAR around the level of service provided, there was a few comments around staff being rude and unprofessional. SA asked how TO had responded to those comments and if there had been staff training put in place.

TO confirmed that he receives copies of the complaints, then either himself or the regional manager will visit the pharmacy to have discussions with relevant member of the team alongside the pharmacy manager. They also have monthly meetings where customer service is included and training to upskill and educate staff and if there are customer service issues then the manager will address this in the normal process.

SA asked if those comments were normal or if TO was surprised around the feedback.

TO was surprised in the case of that particular pharmacy as he feels they have a good relationship with their providers, including GPs, Physio's and also the patients in the local community. He believes there is always frustration particularly if the waiting times are longer than normal or if an item is out of stock and they have to procure it from elsewhere which may lead to frustration, although that is not the case on a daily basis.

10/22.7 Questions from Mr Ray Kelly (RK) to Mr Tony O'Reilly (TO)

RK asked TO if he was in agreement with the neighbourhood of the applicant.

TO agreed with the applicant's neighbourhood.

RK asked if TO agreed that he could change his opening hours back to the core hours.

TO agreed he could do but he was trying to mirror the hours of the surgery by opening at 8.30am to look after those patients.

RK asked TO, if when people are unwell did he think they would travel to a pharmacy next to where they work or the one in their home town.

TO stated that people do not necessarily go to Burntisland High Street if they are travelling outwith the area to access other services or amenities.

RK asked how many people are working in Lloyds Pharmacy in Burntisland.

TO confirmed that there are 11 people altogether. One pharmacist, a manager, who is not a pharmacist, one ACT and the rest of the team are NVQ level. There are part time staff and just over 5 full time equivalents.

RK asked if the 20% response rate to the CAR that TO had referred to was for other applications in Fife or if it was this particular applicant in Townhill.

TO confirmed it was this particular applicant in Townhill.

RK asked if there are any core services that Lloyds Pharmacy do not provide.

TO confirmed Lloyds Pharmacy provide all core services and also Methadone with 20 to 25 service users, with the ability to expand if needed.

RK asked if Lloyds Pharmacy provide CMS.

TO stated that they do provide CMS but not many, maybe around 20 patients.

RK asked if TO agreed that 20 patients is a pretty low number of patients.

TO agreed, but stated that this service is driven by the practice rather than the pharmacy.

RK asked, in terms of closing at lunchtime and at the beginning and end of the day during the pandemic, was it specifically Lloyds Pharmacy in Burntisland or if the closures were a more general thing agreed with the Board.

TO confirmed this was every pharmacy in the UK not only Lloyds Pharmacy. This started in March 2020 but went back to normal in summer 2020, although the provision from the Health Board still exists. If there is a need to make lunchtime closures then it is acceptable to do so as long as the Health Board is notified.

RK asked if Lloyds Pharmacy had refitted and relocated twice.

TO stated that they had refitted the old premises once and relocated once in 2018 to purpose built premises.

10/22.8 Questions from Mrs Cara MacKenzie (CM) to Mr Tony O'Reilly (TO)

CM asked how TO had found recruitment of his support staff for the pharmacy in the local area.

TO believed that for Lloyds Pharmacy in Burntisland it has been good but generally it takes three times longer than it would have taken pre covid. The dispensing staff received a 7% wage increase this year to bring them above the national living wage to help support and retain them within the business.

10/22.9 Questions from the Chair (Ch) to Mr Tony O'Reilly (TO)

Ch asked why TO believes it is satisfactory to have a locker box next to Lloyds in Burntisland but it is not satisfactory for a new application to be granted.

TO stated that the locker box has not been obtained through a legitimate application process, it has been done underhand and is subject to the Legal Test. Dears cannot provide other pharmaceutical services but they are able to furnish prescriptions and any private pharmacy services.

The Ch referred to the CAR where the vast majority of responses indicated that the pharmaceutical services provided from Lloyds Pharmacy are inadequate and asked TO if there is an inadequacy of provision from Lloyds Pharmacy to the community of Burntisland.

TO did not agree, he believed this would depend on what someone deemed necessary or just nice to have. If you ask anyone In a community if they would like another pharmacy or GP Practice etc the answer would overwhelmingly be yes. That is not the Legal Test, the Test is, is it necessary to have another pharmacy, which it is not, and is it required, in terms of provision, in which case Lloyds believe they are providing an adequate service to the community.

10/22.10 Mrs Carol Rogers (CR) spoke to her presentation. (Attached Appendix 4)

INTERESTED PARTIES QUESTION MRS ROGERS

10/22.11 Questions from the Applicant (MA) to Mrs Carol Rogers (CR)

MA asked CR what makes Burntisland Community Council so different.

CR believes Burntisland Community Council is a proactive Council who are passionate about the community feeling and very engaging, passionate and focused on the needs of Burntisland.

MA asked what the Burntisland community has experienced regarding the shortage of supplies and the lack of a pharmacist pre covid.

CR believed that the general consensus was that Lloyds Pharmacy was too busy, causing long waiting times and queues for prescriptions.

CR reported that when Lloyds Pharmacy are providing their service the staff are very helpful and knowledgeable but constantly under pressure due to the shop being so busy and constantly having queues.

MA asked if these comments were over the 10 year period when Lloyds Pharmacy had one pharmacist, then two pharmacists, pre covid.

CR had not noticed a difference but she did not frequent the high street, but what she did know was that people had been asking for a second pharmacy for 15 years. She stated that through the covid pandemic things had been difficult but they had been difficult pre covid and continue to be post covid.

MA asked what CR's personal experience is with Lloyds Pharmacy.

CR reported that the staff in Lloyds are lovely and a credit to them, however she has never gone in and not had to wait a considerable amount of time.

10/22.12 Questions from Mr Chris Freeland (CF) to Mrs Carol Rogers (CR)

CF asked if CR was aware of the reason why the PPC had not granted the last two applications to open a pharmacy in Burntisland when the population had not particularly changed much and there has not been an extensive increase in the volume of prescriptions.

CR was not familiar of the working of the PPC, but felt quite perplexed why the applications for a pharmacy in Burntisland keep being rejected when there are clearly issues.

CF asked if she was aware, if in similar areas, the waiting times are the same as Lloyds Pharmacy in Burntisland.

CR was unsure as she used her local pharmacy but if a second pharmacy was to be granted she believed this would alleviate the pressures that Lloyds Pharmacy face as some of the waiting times, in her personal opinion, are not acceptable.

CF asked if she felt it would be more convenient to have a second pharmacy.

CR felt this was under playing it as she believed if a patient builds up a relationship with their pharmacy it is more important than convenience. She also believed that a pharmacy alleviates problems for GPs. She was of the opinion that if people are afraid to go into a pharmacy because of a Methadone problem, the word convenient becomes a bit flippant.

CF asked CR, if a second pharmacy opened and did not offer Methadone would the same problem not still be there with the current pharmacy.

CR believed that if there is one pharmacy who offers Methadone and one who does not, the people that find the Methadone programme intimidating have a choice.

10.22/13 Questions from Mr Tony O'Reilly (TO) to Mrs Carol Rogers (CR)

TO asked CR what she thought might be the case if Lloyds Pharmacy in Burntisland stopped servicing Methadone patients.

CR felt this would be a very serious issue as these people have an acute health need.

TO asked CR why she felt it would be satisfactory for a second pharmacy in Burntisland to discriminate against the Methadone population, who have a valid prescription and a medical need.

CR did not feel it was discrimination, and pointed out that she thought MA believed there was no need for a second pharmacy to dispense Methadone. She felt that it could be seen as discrimination, people not having a safe alternative to go where they do not have that intimidation. An alternative pharmacy could mean a better service all round.

TO believed that a patient should have the choice to go to any pharmacy and be able to get their prescription dispensed.

CR agreed but she believed they should also be able to go to a pharmacy and feel safe and discuss health issues and not have to go to a pharmacy who provides an Opiate programme and feel unsafe. She believed that having a pharmacy where they did not provide a Methadone programme would be the best service for everyone.

COMMITTEE MEMBERS QUESTION MRS ROGERS

10/22.14 Questions from Mr Arthur Andrews (AA) to Mrs Carol Rogers (CR)

AA asked CR if the figure quoted from TO of 400 and her own figure of 17% were the same.

CR stated that she was pulling the figures from the rate of growth in Burntisland compared to the average growth in Fife just to highlight that Burntisland is thriving, so she was unsure if they were the same figure.

AA asked CR if she or the Community Council had approached Lloyds Pharmacy about the deficiencies in Burntisland i.e. waiting times, queuing etc.

CR confirmed that she had not approached them but the information was in the CAR.

AA asked if CR had seen PPC Minutes indicating that any conversations between Lloyds and the Community Council had taken place.

CR was not aware of any.

MA asked the Chair if he could intervene.

MA stated that prior to CR joining the Community Council, Mr Gordon MacDonald had tried on several occasions to contact Lloyds Pharmacy but they had not engaged, which is highlighted in their presentation.

10/22.15 Question from Ms Sandra Auld (SA) to Mrs Carol Rogers (CR)

SA asked CR if she had sight of the SNP Community Council's 2015 survey that had been mentioned earlier and if it had corresponded with the CAR.

CR was not aware of the survey.

SA referred to the Action Plan, where it was mentioned local services being the main priority and to improve pharmacy services. There was a comment that the intention was to lobby NHS Fife to expand on pharmacy services. SA asked CR if she was aware whether NHS Fife had been contacted or not.

CR had a copy of a letter, dated 31 December 2020 sent from the Chair of the Burntisland Community Council, Mr Alex MacDonald, to Linda Neave at Primary Care, mapping out the

Community Council's position, showing support and giving the reasons why there was a need for a second pharmacy in Burntisland.

SA asked CR how she felt it would be received with people in the town if the locker box next door at Dears Health and Beauty store were to be stopped.

CR believed that, although the locker box was not a pharmacy, it dispenses prescriptions, and if it were to suddenly disappear, they would think of it as another blow to the town.

10/22.16 Questions from Mr Ray Kelly (RK) to Mrs Carol Rogers (CR)

RK asked CR if it would be fair to say that the number of responses to the CAR had increased due to the fact that Burntisland has a highly motivated Community Council and the residents of Burntisland have desired a second pharmacy for 15 years.

CR felt it was difficult to comment without knowing all the facts. She was unsure why some people did not respond to the CAR or how much access the residents had to the online Consultation.

RK asked CR if she would accept that providing a safe place is not a core service for a pharmacy as yet.

CR agreed but her understanding was that people should be able to feel comfortable chatting and asking for advice when visiting their pharmacy.

In terms of the Legal Test and adequacy, RK asked CR how many pharmacies there are currently in Burntisland.

CR confirmed there is one pharmacy.

RK referred to CR mentioning Lloyds Pharmacy's responses to the CAR being 20% versus 7% responses to this application and asked where she acquired her information as this was not in any of the papers.

CR confirmed this was from an appeal in response to an application for a new pharmacy at 91 High Street, Burntisland. She obtained this information to enquire how the PPC works.

RK asked what the benefit would be to the Board, if they granted a new pharmacy contract to a pharmacy who did not provide Methadone and picks only the services they wish to deliver.

CR did not agree this is the case. She believed that, if all the pharmacies are in agreement that Lloyds are providing an adequate service for Methadone and there is no requirement for an additional methadone service then this would be devised strategy planning.

RK asked if CR would be surprised to learn that he had never seen an application for a pharmacy where they did not offer every service they could potentially offer.

CR was not surprised as she had never been involved in this type of application before.

RK asked if the new housing at Greenmount is in the Fife Plan and zoned for housing only and if this is a place where they have broken ground and will be building in the next few months.

CR confirmed that Greenmount had been given planning permission to build 10 to 15 houses but have not broken ground so far. At the Grange Distillery they have broken ground and have planning permission however there have been problems with the contractor going into liquidation but she believed this is now going ahead with a different contractor and the Kirkton Lea development is currently being built.

In terms of the Methadone programme RK pointed out that CR had said there was a negative attitude to the programme from the Burntisland population and asked her to clarify.

CR implied that she would not go as far as saying there was a negative attitude, but perhaps a slight element of fear or mistrust around the programme as there is a perception that along with the Methadone programme there are other social issues. She accepted that this is not the responsibility of Lloyds Pharmacy but did believe people find it intimidating at certain times of the day to visit the pharmacy.

The Chair intervened as he felt that Methadone should not be brought into consideration.

The Applicant also agreed as this is not part of the core services and felt this was unfair questioning.

RK apologised and moved on to ask CR how necessary she felt there was a need for a second pharmacy on a percentage basis.

CR believed personally that the percentage was over 80-90 percent at the least.

10/22.17 Questions from Mrs Cara MacKenzie (CM) to Mrs Carol Roger (CR)

CM asked CR if it would be a fair assumption to make, that due to patients feeling intimidated, if another pharmacy were to open and many of the patients moved there, Lloyds pharmacy would become much less viable.

CR believed it was more elderly people that were intimidated and would be more comfortable using another pharmacy and not the vast majority that would boycott Lloyds Pharmacy.

10/22/18 Questions from The Chair (Ch) to Mrs Carol Rogers (CR)

Ch asked CR if she believed there was an inadequacy of pharmacy services in the existing pharmacy due to the fact that people are using the locker box next door.

CR believed this was the case.

11/22 INTERESTED PARTIES SUMMING UP

11/22.1 Mr Chris Freeland (CF)

CF felt that the Legal Test must be considered in granting an application. He believed Burntisland was a neighbourhood with adequate local core pharmacy services. The Applicant is not offering services over and above the current pharmacy services which means he is not offering to support the least deprived members of the community. Many complaints are over convenience, which is waiting times. One pharmacy can provide

services to a population of around 6,600 which are in general good health. CF believed the application fails the Legal Test and recommended it should be rejected on these grounds.

11/22.2 Mr Tony O'Reilly (TO)

TO asked the panel to refuse the Application on the grounds that it is not necessary to have another pharmacy in Burntisland. The number of responses, although positive in the CAR were not overwhelmingly reflective of the population of Burntisland. Lloyds have changed their structure in the pharmacy to provide adequate service to their patients. The pharmacy offers all the core services, additional services and they do not charge for a delivery service which is not part of the core NHS contract. He believed it is also a dangerous precedent for an applicant to choose the services they will not engage with, even though there is a patient need and requirement for a particular service. This may affect the long term viability in the existing pharmacy within Burntisland, where they have made significant improvement and investment in the premises in order to cater for the needs of the population. He did not feel another pharmacy within the town where it is not required would be an adequate use of NHS Fife's resources.

11/22.3 Mrs Carol Rogers (CR)

CR hoped that she had been able to portray the really strong feeling in Burntisland and she respectfully disagreed that the pharmacy service is adequate and that the anecdote of the people proves that it is inadequate. This is not a personal attack on Lloyds but felt the staff are under pressure and therefore people are not getting the service that they require. This is not just about convenience but about an essential service.

12/22 APPLICANT SUMMING UP

12/22.1 MA spoke to his paper. (Summary attached as Appendix 5)

13/22 NOTIFICATION OF OUTCOME

13/22.1 The Chair asked all those present whether or not they felt they had had a fair hearing, they all confirmed that they had.

13/21.2 The Chair thanked the Applicant and the interested parties for their attendance and before asking them to leave advised them that the decision would be notified to them in accordance with the timescales laid down in paragraph 1, Schedule 3 of the Regulations.

THE APPLICANT, INTERESTED PARTIES AND PRIMARY CARE MANAGER WITHDREW FROM THE HEARING.

14/22 In accordance with the Legal Test, the Committee considered whether existing provision of Pharmaceutical Services in the neighbourhood was adequate. If it decides that such a provision is adequate, that is the end of the matter and the Application must fail.

In considering the Application the Committee took account of all relevant factors concerning neighbourhood, the CAR, the PCSR, the written and oral evidence and adequacy of existing Pharmaceutical Services in the neighbourhood in which the proposed premises would be located, in terms of regulation 5(10).

It also took account of all information available to it which was relevant to the Application

14/22.1 **The PPC were required and did take into account all relevant factors concerning the issue of:-**

a) Neighbourhood

b) Adequacy of existing Pharmaceutical Services in the neighbourhood and, in particular, whether the provision of Pharmaceutical Services at the premises named in the Application were necessary or desirable in order to secure adequate provision of Pharmaceutical Services in the neighbourhood in which the premises were located.

Proposed premises

The location for the proposed pharmacy is within 94 High Street, Burntisland, Fife, KY3 9AS

14/22.2 **Neighbourhood**

Having considered the evidence presented to it by the Applicant, the interested parties, the Consultation Analysis Report and NHS Fife's Pharmaceutical Services Report the PPC had to decide firstly the question of the neighbourhood in which the premises to which the application related were located.

The Committee agreed with the neighbourhood as defined by the applicant which was the town of Burntisland but not any outlying areas. They noted that there had been no objections to this definition of neighbourhood by any of the objectors.

The neighbourhood was agreed as the whole of Burntisland as follows: North: The Binn, East: from The Binn to Dodhead Golf Course, then Linwell Court, then Forth Estuary, South: Forth Estuary, West: from Forth Estuary to Starley Hall School, then Bendameer Road, then Grange Farm, then The Binn.

14/22.3 **Adequacy of Existing Provision of Pharmaceutical Services and Necessity or Desirability**

Having reached a conclusion as to the defined neighbourhood, the Committee was then required to consider the adequacy of Pharmaceutical Services within or to that neighbourhood and, if the Committee deemed them inadequate, whether the granting of the Application was necessary or desirable in order to secure adequate provision of Pharmaceutical Services in the defined neighbourhood.

In order to assist the Committee in reaching their decision, they took into account the following:-

14/22.4 **Consultation Analysis Report**

The Committee considered and noted the content of the CAR. In particular, the following point was taken into account:

Question 2 – Do you think there are gaps/deficiencies in the existing provision of pharmaceutical services in this neighbourhood. Although 382 out of 451 respondents had

said there were gaps/deficiencies, 52 had agreed the service was adequate which the Chair considered to be a very high number as usually this report favoured the applicant.

SA advised that she was having difficulty with accepting the service currently provided was adequate as the strength of feeling coming from the CAR was quite responding in how unhappy people were with the service being provided to them. She felt that patients were not looking for the convenience of a second pharmacy, it was about frustration with the level of service.

SA advised the Committee she had been shocked at the comments on how customers of Lloyds are treated by pharmacy staff.

14/22.5 **NHS Fife's Pharmaceutical Services Report 2019-20**

AA highlighted that that NHS Fife's Pharmaceutical Services Report 2019-20 stated that there were no gaps/unmet needs in the provision of Pharmaceutical services to the neighbourhood.

The Committee expressed their concern that they were being asked to make this decision with a report that was two years out of date.

AA enquired if there was an update on the report. He was advised that due to the COVID pandemic, this was the most up to date report.

CM stated that as the population of the neighbourhood had only gone up by 400 patients since 2011 there probably had not been any changes from the 2019-20 report.

14/22.6 **Pharmaceutical Services already provided in the neighbourhood of the premises named in the application by persons whose names are included in a pharmaceutical list**

Current Pharmaceutical Services provided in or to the neighbourhood were considered (evidenced by the CAR, contracted Pharmacy representatives and the Applicant).

AA stated that he thought the current service was adequate but that the mechanism for providing it was not.

RK advised that in terms of the legal test for adequacy, it was not if the service was poor and that adequacy was a question for the Board. They had to determine whether or not there was a sufficient service provided to the population that the Board is responsible for.

The Committee noted that the current pharmacy had passed an inspection by an Independent Inspector and were of the view that had the inspector deemed the service provided inadequate Lloyd's would have been advised they were at risk of losing their NHS contract.

CM advised that she thought the service currently being provided was adequate as Lloyds were currently providing all the core services and some Enhanced Services but agreed they may not be providing the best service. She highlighted that although long waiting times had been mentioned, no-one had said they never received their prescription.

SA highlighted that the guidance given to the Committee did not provide a definition of adequate. She wondered if a pharmacy was passed by the Pharmacy regulator, did that

mean the Committee had to assume that all pharmacies unacted upon were adequate. She advised that she felt that as complaints regarding the current provider had been made this would suggest that the service was not adequate. She stated that in her opinion this was not an adequate service.

SA was advised that the Board relied on pharmacies providing the number of complaints they received and were not made aware of the nature of the complaints.

RK asked if the only solution, as suggested by the applicant, was to provide a second pharmacy. In this case, it would be a second pharmacy that was choosing which services it would or would not provide including not providing a methadone service because it would provide them with support from a section of the local community. He stated a pharmacy should be one for all purposes and that if the applicant used figures in his application saying that the neighbourhood is highly deprived, how can he then exclude a service to a proportion of the most highly deprived patients.

SA stated that she was uncomfortable with the applicant's decision not to provide a Methadone Service. However, she felt the ongoing wishes of the Community, over a long period of time, were not being addressed here.

RK reminded the Committee that they needed to look at what it was mandated to do in terms of the Regulations, by factoring in all the evidence, which is, is the service adequate in terms of what services Lloyds are providing, or is there anything they are not providing.

RK highlighted that Lloyds were currently providing every core service and as that the neighbourhood already had a pharmacy the size of population did not justify a second one. He advised that areas which already had multiple pharmacies tended to be historic businesses, not new contracts.

RK believed that the application did not meet the legal test in that the current provision, although not wonderful, is adequate. He advised it was not for this Committee to decide if the current service was poor.

CM stated that it was important to note that although the Committee thought the service provided by the current pharmacy was adequate it was not considered to be an excellent service.

RK reiterated that assessing the standard of service was the responsibility of the Inspectorate, who has the authority to close down a pharmacy should standards not be met. He stated that complaints were always highlighted more than good service.

14/22.7 **Information available to the Board which, in its opinion, is relevant to consideration of the application**

The Committee noted that the APC had highlighted that there had been little change in the population of the proposed neighbourhood since a previous application had been refused in 2016-17.

It was also noted that the APC considered that the current provider was providing all the required services and had recently upgraded their pharmacy premises.

14/22.8 **Information provided by the Community Council**

The Community Council had highlighted to the Committee that Methadone patients were moved up the queue in front of other patients. CM informed the Committee that when she had worked in a Community Pharmacy, they had also dealt with methadone patients first so that other customers would feel more comfortable and not afraid. She continued that she felt the contract awarded to Lloyds by the Board was adequate for the size of the population.

RK reminded the Committee that although the Community Council had provided several emotive anecdotal accounts of the service provided by Lloyds, the Committee had to base their decision on the requirements of the Legal Test of neighbourhood and adequacy.

14/22.9 **The likely long-term sustainability of the Pharmaceutical Services to be provided by the Applicant**

RK highlighted that having a pharmacy for just over 6,000 patients, as was the case with Lloyds in Burntisland, would mean it was very busy with potentially longer waiting times than patients were willing to accept, but that did not make it inadequate. He stated that the average number of patients per pharmacy in Scotland was around 6,500.

RK reminded the Committee that this application was for a second pharmacy in an area where the population size does not justify one.

15/22 IN ACCORDANCE WITH THE STATUTORY PROCEDURE THE PHARMACIST CONTRACTOR MEMBERS OF THE COMMITTEE AND THE NOTETAKERS WITHDREW FROM THE MEETING DURING THE DECISION MAKING PROCESS

16/22 COMMITTEE VOTE AND DECISION

The Committee vote was tied, therefore the Chair used his casting vote to decide that the service provided in the proposed neighbourhood was adequate.

The Chair asked that it be minuted that although the service provided was adequate under the legal test the Committee had reservations about the level of service currently being provided by Lloyds.

For the reasons set out above it was the view of the Committee that the provision of Pharmaceutical Service to the neighbourhood was adequate therefore the Application was rejected.

17/22 ATTENDEES RETURN TO HEARING FOR DECISION

The Committee agreed that the attendees would be notified of the decision by telephone.

Hearing Closed.

Good Morning Ladies and Gentlemen.

I have been a pharmacist for 15+ years and came into the profession at a time when the NHS was radically changing - instead of just having your prescriptions filled at the pharmacy there was a move to offering a range of core services that reduced the load on GP's and even hospitals. I realised the value of becoming more clinically focused and wanted to take that thinking forward to operate new pharmacies. I'm proud to say that my pharmacies have been offering care and addressing health inequalities highlighted in their individual applications.

So you see, I'm familiar with the application process and appreciate the time you're giving me today.

The two big health services in Burntisland are the health centre and the pharmacy. For the past 20 years Census data shows us that Burntisland has increased by 15% since 2001. This is having a burgeoning effect on these services, they're unable to cater to the growing population - they're stretched. But in 2015 more doctors were brought in to address the lack of appointments and things drastically improved. However the problem still remains for pharmacy - there's still a single provision. If data suggests there's more gp appointments needed then more gps are put forward. Its as simple as that, other GP's are not asked because they don't go through a regulatory process. But the situation for community pharmacy is very different.

My single aim today is to prove to you that over the past 15 years the current pharmacy has been struggling to cater to this growing population, and that it consistently offers an inadequate level of provision to this community - with brief periods of improved provision when decision makers (i.e. the board) examine the provision in Burntisland. I will prove this by looking at evidence provided by 3 key players. The Community Council, the HealthBoards public consultation, and the elected councillors.

Slide 1 - Neighbourhood & Population

I won't talk in detail about the amenities of Burntisland, suffice to say the neighbourhood is Burntisland in its entirety and is a neighbourhood of all purposes, with its boundaries clearly expressed in the application. What I will talk about is the population.

The 2020 Mid Year estimate shows that the population is 6,620. However, this doesn't cover the neighbourhood fully. There are three datazones that surround Burntisland that have a total population of 2,061. We already know that Burntisland is a thriving area more so than Kinghorn and Aberdour. Taking a conservative approach, we can safely say that at least 1,000 of these people will be accessing the many services of Burntisland. This shows that Burntisland caters to a minimum of 7,620 people [transition]. A sizable number for only one pharmacy to serve.

Slide 2 - GP Comparison

And this is reflected in the practice list sizes of the surgeries in Burntisland - showing that the surgeries cater to a larger population than Burntislands population. Also, the practice list size is more than double that of Kinghorn, and Aberdour does not have a dedicated GP surgery

Slide 3 - Inadequate & Erratic Service

This table shows you a timeline of 15 years, of inadequate provision, thats documented by various organisations

Slide 4 - Inadequate & Erratic Service

It starts in 2008 local residents supported a new pharmacy application where they state long waiting times, poor staffing, and stock issues with Lloyds. The PPC stated that eventually another pharmacy would be needed because Burntisland was growing.

At the hearing Lloyds pharmacy made commitments to the PPC:

Slide 5 2008 Lloyds Commitments

- Promised a second pharmacist to bring down the waiting times
- And that they would extend into the shop premises next door because of the lack of existing space.

They said by addressing staff shortages it meant pharmaceutical services were now adequate.

But the problems quickly resurfaced because the crucial 2nd pharmacist cover fell through.

Slide 6 - Inadequate & Erratic Service

In 2015 Burntisland Community Council proved that another pharmacy is needed by engaging with 500 people and doing a focus group session of 350 people. They bought in external agents to conduct this engagement and to produce a Community Action Plan for them. And a top priority of the plan is to address the problem that one pharmacy simply cant serve Burntisland and that they want to

"Lobby NHS Fife to extend the local provision of pharmacy services"

So why are hundreds of residents engaging with these external agents saying that they want another pharmacy. Most areas in NHS Fife of this population size benefit from 2, sometimes even 3 pharmacies.

Slide 7 - Inadequate & Erratic Service

In 2016 Burntisland residents supported another pharmacy application. The PPC determined that the existing provision was inadequate but couldn't support an application that had no purpose built premises or even planning. Interestingly the APC also said a pharmacy would be desirable. Most APC's usually object or have no say.

It's important to appreciate when inadequacies are proven a pharmacy contract is granted - but not here. I've never come across a situation like this.

There was an appeal and a re-hearing took place where Lloyds made commitments again....

Slide 8 - 2016 Lloyds Commitments

They

- Brought in a second pharmacist to bring down the waiting times - extra 38 hours of working staff
- Brought in a Dispensing Technician
- Increased opening hours
- Done another minor relocation

Slide 9 - Inadequate & Erratic Service

Even with these improvements, the PPC felt that the current provision was "still bordering on inadequate provision". However, the application was unsuccessful and shortly after the problems quickly resurfaced and the crucial 2nd pharmacist cover fell through AGAIN. So you can see a pattern emerging here.

Slide 10 - Lloyds Commitments Failed again

It's disheartening that the Community Council's recent letter of submission reiterates these broken promises.

"a second pharmacist would be in place on a regular basis to deal with the excessive pressure, this only lasted for a brief period"

Slide 11 - Inadequate & Erratic Service

Some years later, I approached local residents and leaders of the community and I came to learn that problems were worsening.

So I worked with the Board to launch a public consultation.

The findings of the consultation cite all the issues previously mentioned and the CAR clearly states that there is a continuous theme that the current pharmacy is inadequate.

Slide 12 - Inadequate & Erratic Service

What's been happening since the public consultation. No doubt Lloyds will say today that since the 2019 public consultation things have got better... cue the commitments again. Most recently, the Community Council's letter of submission confirms that there are still "chronic problems of inadequate pharmacy services".

Slide 13 - Issues After Public Consultation.

Not only has the loss of the second pharmacist affected service delivery in a big way, it's been further exacerbated by around 40 weekly hours of other key staff being cut during covid. The parent company of Lloyds has been strategically lowering operating expenses i.e. on the ground workers. As a result they've experienced higher profits of 239% compared to the year before COVID as stated by Executive Britt Vitalone

When you have staff cuts, then staff retention becomes a problem too. There is added pressure on existing staff and they end up leaving, that's been happening here too, this Lloyds branch has found it difficult to keep a pharmacist manager. In a branch where there are clear issues, there should be an increase in staff not a reduction.

Slide 14 - Inadequate & Erratic Service

The elected councillors of this area confirm that the issues still remain. In their recent letters of submission they cite long prescription waits (20-40 mins), short supply of medicines due to their restricted suppliers, and they explicitly say a new pharmacy is necessary. I attended the community council meeting 2 weeks ago and spoke with attendees - no one is saying that things have improved.

You can see that over a 15 year timeline there are several organisations, and representatives telling us about the continuous theme of inadequacy.

I believe it's very unfair for an area of this size that caters to such a large population to only have access to a single pharmacy in this way.

Slide 15 - Key themes in the CAR

450 responses were received, which is an excellent response rate. I believe it's the highest in the Board. So what did the people say?

Key Themes CAR discussion

- First 4 columns relate purely to people saying there are stretched services
- **Slide 7** Highest complaints are for stretched services at the pharmacy specifically (374)
- People elaborate on these comments, the biggest complaint is on long waiting times (327). The community council confirms this in their submission by saying there are "regular waiting times of up to one hour, or people are asked to come back after two to three hours or the next day." **Animation**
- **Slide 8** Comparison of Pharmacy service v GP service is important too. We discussed this earlier, and it clearly shows what happens when the issues are tackled head on. The GP services were massively restructured but nothing has happened for Community Pharmacy - that's why there's significantly more complaints. We have an opportunity to finally fix this.
- **Slide 9** Poor Stock Availability is a concern too. Lloyds is owned by a large wholesaler and they prefer to primarily buy from their own wholesaler AAH and Trident. They will use other suppliers on occasions, but certainly don't have anywhere near the availability of drugs that an independent pharmacy offers. Now if there's only one pharmacy in the area it's a serious problem. Other areas of smaller and similar populations have 2 or more pharmacies, if one doesn't have the medication a patient can easily walk to another pharmacy. We don't have that here.
- Poor staffing - another key theme that ive touched on. The second pharmacist has been cut, and around 40 hours per week of other key staff.
-

Slide 12 Burntisland Pharmacy

This brings us full circle to what I said in my opening statement. The pharmacies that I've helped build, they address specific inadequacies, and there's a lot here that I want the new Burntisland Pharmacy to help fix.

- I want people to get advice quickly and consistently from a HP, right now the staff are busy dispensing and the pharmacist doesn't have the time to speak to patients.
- I want people to have quick and reliable access to medication, by having a wide range of suppliers so we're not beholden to a parent wholesaler company.
- I want people to have prescriptions filled quickly, by increasing staff numbers, and thereby allowing the pharmacy team to focus on other services like pharmacy first, and working more closely with GP surgeries.

Slide 13 - SIMD

Let's examine the health and deprivation of the area.

The Scottish Government says that "SIMD can be used to target policies and resources at the places with greatest need" and services are targeted at the "15% most deprived". Burntisland falls in the 15% most deprived for both health and SIMD.

Slide 14 - Burntisland Health Comparison

This table shows that Burntisland is more Health deprived than the neighbouring areas. The lower the rank the poorer health it has. We can see here Burntisland sits in the 15% most deprived. This shows there's a greater need for health services here (like a community pharmacy).

Slide 15 - Burntisland Health Comparison

Burntisland has worsened in health since 2016 by 3.5%

Slide 16 - Burntisland Overall Deprivation

- Interestingly Burntisland has improved in it's overall deprivation
- Shows that the health inequalities aren't being tackled

Slide 17 - Viability Can Burntisland sustain another pharmacy?
This table shows population sizes in increasing order, and the number of pharmacies they have in NHS Fife. The populations are smaller or similar in size to Burntisland. All of them benefit from more than 1 pharmacy, some of them have 3. So this shows the standard for smaller or similar populations is to have more than one pharmacy in NHS Fife.

Slide 18 - Viability
This table shows the same thing across Scotland.

- Pitlochary benefits from 2 pharmacies and it has a significantly less population.
- **Slide 19** Both Blackburn and Lesmahagow have 2 pharmacies. These are new village contracts and have significantly smaller populations. Both pharmacies in each community are coexisting and are viable
- **Slide 20** Gorebridge has a similar population to Burntisland which has two lloyds pharmacies. All this again proves that two pharmacies can comfortably co-exist

Slide 21 - Delivery Service
It's interesting to note that Aberdour Pharmacy is in attendance today as they were not invited to any previous applications. The only way it can serve Burntisland is through a delivery service. But its impossible to serve a population of 7,600 from 3.2 miles away. There are other issues, in that a delivery service masks residents' difficulty in accessing the most immediate pharmacy, and crucially, it does not allow Core Services to be delivered. Pharmacy services are largely accessed by patients coming into the pharmacy, having face to face interaction with a healthcare professional. This is why large chain multiples are moving away from offering the delivery service and in fact the Head of Lloyds says "there is less interaction with a pharmacist" through such a service. The pharmaceutical care plans, NAP, and various other PPC's across Scotland feel that delivery is not a service and can be withdrawn at any time.

Slide 22 - APC

I would like to address the points the Area Pharmaceutical Committee has made in their submission. The APC says the previous application was very recent and there's no material change. I beg to differ, the reality is that the application was more than 6 years ago and we've heard from various organisations that the pharmacy has gone back to offering a poor service.

Slide 23 The APC say that there are falling prescription numbers from surgeries but this actually due to reduced appointments during COVID. They're not focusing on the most important metric here - that of prescription numbers at the pharmacies. Lloyds and Aberdour pharmacies have both increased in prescriptions.

Slide 24 The APC says that the population is stagnant, in actual fact it has increased by 15% since 2001 and there are homes that have been approved recently. There are twice as many GP surgeries now.

Slide 25 The APC says that Burntisland is not cited in the Pharmaceutical Care Plan. Since the new regulations none of the 11 new contracts granted were cited in any Care Plan. Crucially, the APC have disregarded the CAR, a legal, and very thorough document which is part of the application process.

All in all the APC is selective in their data and have not taken into account all the information.

Slide 18 - Summary

Burntisland has been suffering from chronic levels of inadequate services. And at brief periods there are impr**ovements but they fall through. That's why the service is erratic as well.**

Key organisations and representatives are saying that current provision is inadequate.

1. The letters of submission from the 3 councillors, who live, work and have family in the area are explicitly talking of 20-40 mins waits in prescriptions and they understand the concerns of a shortage of medicines as well.
2. You would think the community council would have given up hope after 15 years but they're continuing their campaign for an additional pharmacy because they know the solutions put in place by Lloyds are short term. They say that promises are made that last brief periods and that's why in their own words they say

"there's a chronic problem of inadequate pharmacy services".

3. The healthboard is the final key player in this picture, and their robust 90 day public consultation echoes everything that has been said today. I've yet to come across a CAR that explicitly identifies the problem and solution ....

Slide 19 - Boards Findings

That there's a continuous theme of the current pharmacy offering an inadequate service and a new pharmacy will reduce waiting times and relieve pressure.

So you see ladies and gentleman, other areas in NHS Fif**e** with smaller or similar populations benefit from 2-3 pharmacies but don't suffer from these types of inadequacies. Lloyds makes the situation worse by continuing to cut its workforce. It's clear that an additional pharmacy is required. **FINAL ANIMATION**

Bruntisland Application – 26th May 2022

Morning everyone

I would like to thank you for allowing me the time to present my objection to this application today.

In order to grant an application, it is clear that we must consider the legal test and determine whether the current provision is adequate. We must consider the current provision within the neighbourhood and from those without the neighbourhood.

We, Omnicare Pharmacy currently provide a pharmaceutical service to our own neighbourhood Aberdour as well as outlying areas such as Burntisland and Dalgety bay. We provide all contracted pharmaceutical services, with opening hour of 9am to 5.30pm Monday to Friday and Saturday 9am to 12.30pm.

This has not always been the case, until we bought the pharmacy in 2017 the opening hours were half of what they are now. The pharmacy only opened half days and in our opinion wasn't offering a full pharmaceutical service. The delivery service was limited albeit the community enjoyed visiting the pharmacy and was only utilised by those housebound patients in Aberdour, Burntisland and Dalgetty Bay.

In terms of providing a pharmaceutical service to the neighbourhood of Burntisland, we collect prescriptions from the surgery in Burntisland daily and delivery medication daily as well as in emergency situations later in the day. Our driver works full time and not only delivers to Aberdour and Burntisland but Dalgety as well. While this is not a contacted service it helps many patients who are housebound and cannot reach any pharmacy close to where they live.

Our prescription number have grown over the last 5 years not dramatically, but as a result of our increased opening hours and more residents of Aberdour using our services instead of having to go to Dalgety bay or Burntisland. We also service a couple of care homes in the area.

Do we do many prescriptions for the residents of Burntisland, very few. Have numbers of prescriptions dispensed by us from Burntisland or even Dalgetty bay grown over the last 5 years, not dramatically.

So where do people from Burntisland access pharmacy services, Lloyds Pharmacy, in the heart of their high street. Lloyds provide all core contracted services, full opening hours 6 days per week along with a delivery service.

Since our increased opening in 2017, Lloyds have also enhanced their service by moving into a large purpose built premise. I am sure Tony representing Lloyds will be able to give you further details, however having a close relationship with the surgery in Burntisland there has been no discussion with them regarding patients either having poor access to pharmacy services or any inadequacies in pharmacy service.

All of these changes have come about since the previous application decision in 2008 to refuse the application on the grounds that the then existing pharmaceutical service was adequate. They noted then access to pharmaceutical services is readily available on foot, by public transport or by car and the panel did not find the availability of parking spaces to be an issue.

In the application in 2016 the PPC found existing services to be inadequate, however the application was neither necessary or desirable to secure adequate provision.

So what do we know that since those decisions

- Opening hours have increased
- The pharmacy premise in the neighbourhood has been dramatically enhanced
- There has be no significant change in population to put pressure on existing services.

Out with pharmacy services what has changed dramatically to affect access to pharmaceutical services.

The population of Burntisland hasn't grown significantly, at the point of the previous application in 2016 the population was stated at 6,500. It is now around 6,600.

Dalgety bay has a population of around 10,000 with one pharmacy servicing that neighbourhood.

Obviously, demographics can play a part in those that require more access to healthcare service, however equally there are more people within Burntisland that don't require as much pharmacy intervention. Working families will also travel outside the neighbourhood to access pharmacy services. Including parents with children in secondary education, who travel daily to drop off and collect there children in Dalgetty Bay. They will also do there main shopping outwith Burntisland.

Around 70% of the the population of buntisland work and will travel to the likes of Edinburgh, Kirkcaldy, glenrothes or Dunfermline for this purpose. There is every likelihood they will use pharmacy services in these areas.

The public consultation was carried out to obtain the level of support of the resident of Burntisland, of the population only 451 residents took park. This represents 6.8% of the population.

Only 5.7% of the population of burtisland said there were gaps/deficiencies and even less 5.2% said the services being proposed by Burntisland pharmacy were actually required. I am no statistician but that is by no means overwhelming support and clearly demonstrates the majority of the population feel the current service is adequate.

The APC clearly state in their correspondence

- Population is stagnant, something I have also concluded
- No plans for significant large scale housing proposals which would affecting prescription volumes at surgery and pharmacies
- They noted substantial investment in the current pharmacy
- Pharmaceutical care services document identifies no gaps/unmet need within the current network
- No material change since previous applications were rejected

The legal test

So by definition, the legal test states the committee must consider whether the existing provision in the relevant neighbourhood is adequate.

In order to decide this, then you need to consider if the population of the defined neighbourhood has poor access to pharmacy services. The answer to this is no, there is a pharmacy in Burntisland and provides all core services in a large high street unit, purpose built for this exact purpose. Our pharmacy in Aberdour also provides access to services for those that work in the village or pass through for convenience. A prescription pick up point has also been created in Burntisland to allow residents to collect prescriptions at there convenience. Is this a full pharmacy service, no, however it does add to how people access there medication.

Within the neighbouthood of Burntisland is there an inadequacy in the existing pharmacy service. Again, the answer is no.

Is adequacy measured by how long patients need to wait on a prescription, no, pharmacies need time to accurately fulfil prescriptions. The applicant has clearly demonstrated through many local publications, Burntisland is a flourishing community, patient are probably more than happy to leave a prescription to be made up and go an enjoy the local shops and booming community.

During the pandemic there was huge pressure put upon pharmacy services, queues were common and still are. The profession has adapted and there is a huge benefit of having a large space within a pharmacy, Lloyds pharmacy is able to support this.

Does the applicants premise have the space to provide this, NO. Will it force patients to queue outside side, YES. Does it alleviate a potential inadequacy, NO it doesn't.

There has been no complaints from the local surgery over services, we haven't heard reports of frustrated customer coming into us complaining about accessing pharmacy services in Burntisland

Many of the comments in the CAR are over convenience and this is not relevant and should not be considered.

Viability is a significant factor and is required to be taken into account. Granting this application would certainly have a negative impact on current service provision. Recruitment within community pharmacy is a huge issue across Scotland, we ourselves have been advertising for a pharmacist for our Leven branch for nearly a year. We have had no applicants. Creating an additional service in an neighbourhood where it's not required will put further pressure on service.

There is a reason the legal test is clear, it is to stop new contracts being approved in neighbourhood were there is no need and there is adequate provision of services. This is an example of this exact situation.

The existing pharmacy provision to Burntisland from within and located out with is adequate and the application should therefore fail.

APPLICATION MOHAMMED AMEEN - BURNTISLAND

I would like to thank the Panel for allowing me to speak today

The Applicants reason for making this application seems to be that the Pharmaceutical Services provided by current Contractors is inadequate.

Can I firstly point out that since a previous Application was refused in 2016 on the 9th May 2018 Lloyds Pharmacy at a cost of £247,000 (almost a quarter of a million pounds) relocated to even better premises than those deemed adequate at the Previous Hearing

The Applicant may state that the population of Burntisland (6,669)has only one Pharmacy and this is higher than the Scottish Average , however there are examples of Towns that have a ratio similar or indeed higher than that of Burntisland and provide an adequate service , , Linlithgow population 12,840 2 Pharmacies Dalgety Bay population 9,710 one Pharmacy.

During the Previous Hearing the Community Council Representative Mr Mac Donald had stated that the Lloyds premises were situated in a long narrow unit perhaps not fully suitable, at the conclusion of the previous Hearing Tom Arnott the Lloyds Pharmacy Area Manager approached Mr MacDonald and said that should he become aware of any issues in the future to contact himself or the Pharmacy Manager , at no time since then has any Area Manager or indeed the Pharmacy been approached , although hopefully the Community Council will have approved of the Investment Lloyds Pharmacy has made to further improve the service it provides to the Residents of Burntisland

Indeed during that Hearing and I quote Mr Arnott stated I am more than willing at anytime to meet with the Councillors to discuss any further improvements we can make no approach has ever been made

I would also point out that following feedback from the Community Council at a previous Hearing that Lloyds Pharmacy reviewed its Opening Hours , we no longer close at lunchtime and now open at 8.30 a.m. to align ourselves with the GP Surgery
Further evidence that Lloyds Pharmacy continues and will continue to take any actions necessary to provide an adequate service to the Community of Burntisland
At the Previous Hearing it was stated that our premises were not adequate
We have invested almost a quarter of a million pounds in relocating our premises to futureproof them to allow us to provide a more than adequate service to the residents of Burntisland .
The Panel will also be aware that right next door to Lloyds Pharmacy Dears Pharmacy has opened , and although neither ourselves nor indeed the Health Board wanted this facility, it is still able to take in prescriptions and dispense them off site and return them to Patients. In effect there are now 2 Pharmacies able to dispense prescriptions .

I am sure the Panel will agree that any issues that the Applicant has raised about Lloyds service levels , are negated by the opening of Dears Pharmacy being able to dispense prescriptions
I would also point out that since the last PPC the Pharmacy in Aberdour has increased its Opening Hours and indeed the Applicants proposed Opening Hours simply mirror those currently in place.

The Panel will have noted that the vast majority of the New Housing that the applicant refers to, is private housing many of which are large 3 and 4 Bedroom properties
I feel it is also fair to say that the vast majority of the residents of these properties do not work in Burntisland , and so on a daily basis they leave the neighbourhood and access all kinds of services at or near their place of work
Indeed there is no Secondary School in Burntisland and pupils travel to Kirkcaldy on a daily basis to attend Secondary School

Demographics taken from the Scottish Index of Multiple Deprivation show the residents of Burntisland to be generally affluent the vast majority in Good Health and with a more than adequate level of Access to Services including Pharmaceutical Services .

I agree that the population of Burntisland has grown, however it has only grown by 400 residents since 2011 at the same time Lloyds Pharmacy has moved to new premises and has increased the Staffing Levels and Indeed the Pharmacist Cover in the Pharmacy in order to meet the needs of the Residents of Burntisland

The Applicant in support of his application has carried out a Consultation Exercise

If it is part of the New regulations is that the Applicant "must establish the level of Public Support of the residents in the neighbourhood to which the application relates

" **Then** the Applicant has either tried and failed to gain the support of the residents by not trying to access all residents or , as is the case in Burntisland there is little Public Support for this Application
From a Population of 6,669 the applicant received 451 Responses 6.7% of the population AND OF THOSE RESPONSES only 382 5.7% of the population in response to Question 2 Do you think there are any Gaps or Deficiencies in the existing level of Pharmaceutical Care said there were 5.7%
This Applicant has a history of obtaining high response rates to the Consultation Analysis Reports indeed at Townhill the response rate was 21.1% and in Pumpherston 21.0%

I am sure the Panel will agree that such a low response indicates that the vast majority of the residents of Burntisland see no need for another Pharmacy.

The reason for this is that Lloyds Pharmacy in Burntisland provides an adequate service to the residents of Burntisland

The Applicant has provided letters of support.
I have attended many Pharmacy Practice Committee and National Appeal Panel Hearings and at very few of these has there not been a letter of support from the Local Community Council.

I agree that the population of Burntisland has grown, but only by 400 residents since 2011 however at the same time Lloyds Pharmacy has moved to new premises and has increased the Staffing Levels and Indeed has recently benefitted from a further increase in Staffing Levels of 37.5 hours
Athan our Pharmacist is about to start his Independent Prescribing Course and is a great advocate for Pharmacy First, the Pharmacy has a full time Accredited Checking Technician

Lloyds Pharmacy in Burntisland is fully engaged in all Core Services including
MCS (previously Chronic Medication Service) Pharmacy First

The Pharmacy was rated as Satisfactory on its most recent GPHC Inspection with no Action Points
The Pharmacy has a good relationship with the GP Surgery and the Practice Pharmacist

Lloyds Pharmacy offers a full collection and Delivery Service which is FREE Although this is not a Core Service IT IS STILL AVAILABLE

The Panel must take account as to whether the granting of an Application would adversely impact on the security and sustainable provision of existing NHS primary medical and pharmaceutical services in the area concerned.

The following is taken from the NHS (PHARMACEUTICAL SERVICES) (SCOTLAND) REGULATIONS AS AMENDED)
Should the panel deem the existing service inadequate but also consider the applicants business not likely to be viable , and therefore not securing adequate provision of pharmaceutical services , the Application should be refuse

The following is also taken from the NHS (PHARMACEUTICAL SERVICES) (SCOTLAND) REGULATIONS AS AMENDED)
The viability of existing service providers is also relevant in this context
If granting the application would affect viability of those who currently provide a service in the neighbourhood , then it may be that granting the application would have a negative effect upon services in the neighbourhood as a whole Such an application may be refused . Similarly , if the granting of an application would have a detrimental effect

upon the provision of services in the neighbourhood for some other reason , then refusal may be justifiable

I can assure the Panel that the granting of a Contract in Burntisland would have a seriously adverse effect on the future viability of Lloyds Pharmacy in Burntisland

WE HAVE SEEN NO PRESCRIPTION GROWTH IN THE 12 MONTHS TO 31ST MARCH 2022 HOWEVER IN THE SAME PERIOD WE HAVE SEEN PHARMACISTS COSTS INCREASE BY £35,666 I am sure the Panel will **agree this is a significant cost increase**
In all Areas of Scotland Community Pharmacies are struggling to find Pharmacists and granting an unnecessary Contract would only exacerbate the current shortage

The Applicant provides a list of services he will provide
All the services that are available are already adequately provided by Lloyds Pharmacy

The Pharmaceutical Care Services Plan in NHS Fife makes no mention of the need for a further Pharmacy in Burntisland and actually states

"It would appear that overall there are no identified gaps in the provision of Pharmaceutical Services in NHS Fife and it is important to continue to support development of Community Pharmacy Services through Staff Training and ensuring a robust infrastructure for continued delivery of Pharmaceutical Services that meet the needs of the population"
In addition the report has not identified unmet need for new Community Pharmacies across Fife

As stated Lloyds Pharmacy have increased , and will continue to increase Staffing Levels and Pharmacist Cover as necessary to ensure it continues to meet the needs of the residents of Burntisland , as well as reviewing Opening Hours if there is a need .

Lloyds Pharmacy has invested £247,000 in relocating to better premises , Pharmacists Costs have increased significantly and there is no reason to think that in the current climate these costs will reduce
I would ask the Panel to base their decision on the current service provision not any historical or perceived issues

I can assure the Panel that the granting of a Contract in Burntisland would have a seriously adverse effect on the future viability of Lloyds Pharmacy in Burntisland

The Panel must take account as to whether the granting of an Application would adversely impact on the security and sustainable provision of existing NHS primary medical and pharmaceutical services in the area concerned.

The Local Area Pharmaceutical Committee do not support the Application as it is not NECESSARY as there were no identified Gaps in the current Pharmaceutical Service available in Burntisland

I am unaware of any complaints to the Health Board regarding the current service

I would therefore ask the Panel to refuse this application as it is neither necessary nor desirable in order to secure the adequate provision of Pharmaceutical Services in the neighbourhood in which the premises are located

BCC community pharmacy presentation

Introduction

Thank you for inviting me along today to present on behalf of Burntisland Community Council and the people of Burntisland whilst is quite nerve wracking it is also a huge privilege.

I am here today because I personally believe that Burntisland does need an additional community pharmacy and it is very clear that the majority of the people of Burntisland are in support of an additional provision.

I am absolutely not here today to attack the current provider, Lloyds or the work they do but to highlight that one community pharmacy is not enough to cater for the needs of a bustling, thriving town like Burntisland.

Firstly, I would like to briefly share a little bit of my background and why I feel so strongly about this matter.

I am a Burntisland resident and a Forensic Scientist. I work for the Scottish Police Authority. My area of specialism is the investigation into serious sexual crime. Recently, I have worked very closely with the Scottish Government via the CMO Taskforce. The aim of this work has been to improve the provision of forensic medical services to those who have been the victim of rape or sexual assault. Although on the face of it this may not appear related to today's meeting, I will refer back to this later when discussing the importance of the community pharmacy.

The importance of the community pharmacy

The community pharmacy plays a vital role in public health, promoting public health across Scotland. The community pharmacy should be much more accessible than the local GP and seen as the first line in accessing health care within the community.

The CP should provide an informal environment with a level of anonymity that is more conducive to discussing health issues, reaching those groups who are vulnerable and harder to engage with. It provides a safe space where someone can discuss issues that they feel unable to discuss with the family GP.

This leads me back to the work I have been involved in with the CMO Taskforce. I have been working closely with all the health boards in Scotland, including Fife, in the run up to self -referral SO service 'going live'. For those here today who aren't familiar with this – the NHS now have the responsibility to provide a forensic medical examination to victims of rape/SO. They also have the responsibility of providing a 'self-referral' service where victims of SO can access a FME without having to engage with the police. This is a massive step forward in providing a victim centre approach.

So, what has this got to do with the community pharmacy? You might have noticed posters or leaflets in your local pharmacy promoting SARCs? This is what I am referring to. The community pharmacy can play a really important part in raising awareness of this but could be the first port of call for someone who needs help – a victim of SO or domestic abuse may not feel able to approach a Dr but might open up to their local pharmacist. The local pharmacist who builds strong relationships within the community might notice tell tale signs that something is not right and be able to help.

This kind of relationship cannot thrive if a pharmacist is too busy with competing priorities and if the shop is often very busy with long queues.

This is just one example of what can be achieved if the pharmacy environment and provision is appropriate for the size of the town.

Fact and figures supporting an additional community pharmacy provision

Mo has given a very comprehensive run down of the supporting figures so there is no need for me to do the same however I will point out some figures that show the strong support for an additional service.

Mo referred to the Community Action Plan which achieved over 500 responses from local people. The main priority from theme 4 "better local services" was the "inadequacy of having one small community pharmacy in the town" which prompted comments like "The Lloyds chemist in town always appears to be busy and at times under pressure"

Looking to a more recent dataset the Consultation analysis report (CAR) from 2020 also provides support that the feeling within the community of Burntisland is the requirement for an additional pharmacy provision.

451 people responded to this consultation. If you are to assume that these are interested parties from Burntisland which I think is a fair assumption, this equates to 6.8% of the population of approx. 6600. In a previous appeal the Lloyds representative is quoted as saying a response of 7% is the highest he has seen in a consultation, and he would describe that as a good response. I think its fair to say the response to the 2020 consultation is therefore a good response.

1. 85% of respondents felt there were gaps/deficiencies on the existing provision of pharmaceutical services.

Citing issues like.

Long/unacceptable waiting times

Medications being unavailable

Existing pharmacy seemed unable to cope with demand.

Exiting pharmacy is restricted to their availability of suppliers.

2. 85% of respondents felt an additional community pharmacy would have a positive effect on the neighbourhood. I think it's important to note that 17/40 who felt it would have a negative impact put that down to an additional Methadone service being brought into town which in fact would not be the case.
3. Other comments from the respondents supporting an additional community pharmacy are.
    - Reduce waiting times
    - Relieve pressure on GPs
    - Provide choice for locals
    - Is essential due to growing population – we have heard from Mo regarding the growth of the population in Burntisland, but it is also worth noting there are new developments currently underway or in planning – Kirkton Lea, Grange distillery, Greenmount

Anecdotes from local people

Reiterate this is not an attack on the existing provider but reflects that that they do appear to be stretched due one community pharmacy not being sufficient for the town.

Real life examples to illustrate the need.

1. Best friend was terminally ill with cancer and receiving pain medication to allow them to manage illness at home. Lloyds became unable to provide require pain medication, so the lady had to go into a hospice to receive pain medication. This was against her wishes to die at home, and she died in a hospice. Highlights the perils of a pharmacy that is tied to a single supplier.
2. Queueing/weight times whilst those are receiving opioid substitute. Told to return later. Also, intimidation from some who receive opioid replacement therapy making some residents unwilling to visit the pharmacy. A second pharmacy with no opioid replacement programme would provide an alternative, non-threatening space.
3. Queues and wait times in general for prescriptions – wait times of an hour are not uncommon. I have experienced this when visiting the pharmacy with my mum. She had taken a dizzy spell and obtained an emergency GP appointment due to her age. She was confused and scared. We went to get her prescription and was told it would be at least 45 mins. Luckily, I was with her and took her for a coffee, but she was very anxious and upset. I would have preferred to get her prescription and get her home where she felt safe. Instances of being told the wait will be 2-3 hours or to come back the next day.

There is also strong support for an additional community pharmacy provision from local councillors.

Kathleen Lesley (Scottish Conservatives) – “both welcome and a necessity”

Lesley Backhouse (SNP) – “fully supportive of the campaign”

Former Counsellor Gordon Langlands (Scottish Labour Party) – “believe residents require a second pharmacy” laid sown reasons which have all been raised today

Julie MacDougall – (newly elected counsellor for Scottish Labour Party) – “fully supports” second pharmacy in town.

Conclusion

There has been active engagement with the community for several years regarding the need for the provision of a second pharmacy. The most recent consultation and feedback from the community shows support for a second pharmacy has not diminished and that the provision is in the community’s eyes not only desirable but essential and the BCC fully support this proposal.

Final Summary

Why do we need an additional pharmacy?

- The standard in NHS Fife is two pharmacies for a neighbourhood the size of Burntisland. There are sometimes even 3 pharmacies in neighbourhoods like this. This also proves that two pharmacies will be viable.
- Poor staffing. Proof of this is in 2008 when Lloyds said they would bring in a second pharmacist, and then they quickly removed it. There is further proof of this, with the same commitment and removal of the second pharmacist in 2016. Critically, in 2016 there was a promise of 38 hours of additional staff per week, this did not happen, and there's been a further staff reduction during COVID by cutting 40 hours of staff per week which remains today.
- In the public consultation long waiting times are cited an incredible 327 times.
- The community council say there are "regular waiting times of up to one hour, or are asked to come back after two to three hours or the next day"
- This is reiterated by the Elected Councillors saying there are waits of 20-40 minutes.
- There are long standing stock availability issues due the restricted suppliers
- Aberdour pharmacy is 3.2 miles away and cannot provide the core services that it claims to. It's merely picking up the poor delivery service that's being offered by Lloyds. No able bodied person can walk to Aberdour pharmacy.
- Between 2016-20 the health of this population has got worse which means more local health services need to be provided to tackle the worsening situation.
- The current pharmacy cannot cope with the increase in GP numbers since 2016, who are providing more gp appointments and therefore increasing the prescription load on the pharmacy.
- In 2008 the PPC said that another pharmacy would be needed due to the increasing size of the area. And in 2015 the community council had proven this by conducting a very thorough piece of research - the top

priority issue was that Burntisland is too big for only one pharmacy to serve and they wanted to lobby NHS Fife to change this.

- The Community Council says right now "there's a chronic problem of inadequate pharmacy services".
- The healthboard is the final key player in this picture, and their robust 90 day public consultation echoes everything that has been said today. I've yet to come across a CAR that explicitly identifies the problem and solution ....
- That there's a continuous theme of the current pharmacy offering an inadequate service and a new pharmacy will reduce waiting times and relieve pressure.