NHS Fife Clinical Governance Committee

Fri 06 September 2024, 10:00 - 12:45

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Arlene Wood

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Arlene Wood

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Friday 12 July 2024

Enclosed *Arlene Wood*

Approval

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20240712.pdf (13 pages)

10:00 - 10:00
0 min

4. Chair's Assurance Report presented to Fife NHS Board on 30 July 2024

Enclosed *Arlene Wood*

For Information

Item 04 - CGC Chair's Assurance Report 20240712.pdf (3 pages)

10:00 - 10:20
20 min

5. Matters Arising / Action List

Enclosed *Arlene Wood*

Assurance

Item 05 - CGC Action List 20240906.pdf (7 pages)

5.1. Reinforced Autoclaved Aerated Concrete Update

Enclosed *Neil McCormick*

Assurance

Item 05.1 - SBAR Reinforced Autoclaved Aerated Concrete Update.pdf (6 pages)

5.2. Briefing Paper: Alcohol and Drug Death Reviews in Fife

Enclosed *Dr Chris McKenna*

Assurance

Item 05.2 - SBAR Briefing Paper Alcohol and Drug Death Reviews in Fife.pdf (2 pages)

5.3. Reform, Transform, Perform - Acute Redesign Priorities

Enclosed *Claire Dobson*

Assurance

Item 05.3 - SBAR Reform, Transform, Perform - Acute Services Redesign Programme Phase 1.pdf (8 pages)

10:20 - 10:25
5 min

6. ACTIVE OR EMERGING ISSUES

10:25 - 10:55
30 min

7. GOVERNANCE MATTERS

7.1. Clinical Governance Oversight Group Assurance Summary from 20 August 2024 Meeting

Enclosed *Gemma Couser*

Assurance

Item 07.1 - CGOG Assurance Summary from 20 August 2024 Meeting.pdf (5 pages)

7.2. Corporate Risks Aligned to Clinical Governance Committee, including update on Clinical Optimal Outcomes

Enclosed *Dr Chris McKenna / Janette Keenan*

Assurance

Item 07.2 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (7 pages)
Item 07.2 - Appendix 1 NHS Fife Corporate Risks aligned to the CGC as at 20 August 2024.pdf (9 pages)
Item 07.2 - Appendix 2 Assurance Principles.pdf (1 pages)
Item 07.2 - Appendix 3 Risk Matrix.pdf (2 pages)

7.3. Corporate Calendar – Proposed Clinical Governance Committee Dates 2025/26

Enclosed *Dr Gillian MacIntosh*

Decision

Item 07.3 - Proposed Clinical Governance Committee Meeting Dates 2025-26.pdf (1 pages)

7.4. Delivery of Annual Workplan 2024/25

Enclosed *Gemma Couser*

Assurance

Item 07.4 - Delivery of Annual Workplan 2024-25 .pdf (7 pages)

10:55 - 11:05
10 min

8. STRATEGY / PLANNING

8.1. Annual Delivery Plan 2024/25 Scottish Government Response and Quarter 1 Report

Enclosed *Susan Fraser*

Decision

Item 08.1 - SBAR Annual Delivery Plan 2024-25 Quarter 1 Report.pdf (6 pages)
Item 08.1 - Appendix 1 Scottish Government Feedback - Fife Response.pdf (11 pages)
Item 08.1 - Appendix 2 Quarterly Report.pdf (21 pages)

8.2. Scottish Healthcare Associated Infection Strategy 2023-25 Update

Enclosed *Janette Keenan*

Assurance

- Item 08.2 - SBAR Scottish Healthcare Associated Infection Strategy 2023-25 Update.pdf (4 pages)

11:05 - 11:35
30 min

9. QUALITY / PERFORMANCE

9.1. Integrated Performance & Quality Report

Enclosed *Dr Chris McKenna / Janette Keenan*

Assurance

- Item 09.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
- Item 09.1 - Appendix 1 Integrated Performance & Quality Report.pdf (11 pages)

9.2. Healthcare Associated Infection Report

Enclosed *Janette Keenan*

Assurance

- Item 09.2 - SBAR Healthcare Associated Infection Report.pdf (6 pages)
- Item 09.2 - Appendix 1 Healthcare Associated Infection Report.pdf (27 pages)

9.3. Medical Devices Update

Enclosed *Dr Chris McKenna*

Assurance

- Item 09.3 - SBAR Medical Devices Update.pdf (6 pages)
- Item 09.3 - Appendix 1 Medical Devices Policy Framework and Action Plan 2024-2026.pdf (8 pages)

9.4. Organisational Learning Update

Enclosed *Gemma Couser*

Assurance

- Item 09.4 - SBAR Organisational Learning Update + appendices.pdf (15 pages)

9.5. Deteriorating Patient Improvement Programme

Enclosed *Gemma Couser*

Decision

- Item 09.5 - SBAR Deteriorating Patient Improvement Programme.pdf (14 pages)

9.6. Neonatal Mortality Review Health Improvement Scotland Report

Enclosed *Dr Chris McKenna*

Assurance

- Item 09.6 - SBAR Neonatal Mortality Review HIS Report + appendix.pdf (4 pages)

11:35 - 11:55
20 min

10. DIGITAL / INFORMATION

10.1. Digital and Information Strategy 2019-24 Update

Enclosed *Alistair Graham*

Assurance

- Item 10.1 - SBAR Digital and Information Strategy 2019-24 Update + appendix.pdf (8 pages)

10.2. Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme Summary Update

Enclosed *Dr Chris McKenna*

Assurance

Item 10.2 - SBAR Hospital Electronic Prescribing and Medicines Administration Programme Summary Update.pdf (5 pages)

10.3. Information Governance and Security Steering Group Update

Enclosed *Alistair Graham*

Assurance

Item 10.3 - SBAR Information Governance and Security Steering Group Update.pdf (9 pages)
Item 10.3 - Appendix 1 Exec Summary - IGS Accountability and Assurance Framework.pdf (10 pages)

10.4. St Andrews Community Hospital Security Breach Update & Action Plan

Enclosed *Margo McGurk*

Assurance

Item 10.4 - SBAR St Andrews Community Hospital Security Breach Update & Action Plan + appendix.pdf (7 pages)

11:55 - 12:15
20 min

11. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

11.1. Patient Story

Janette Keenan

11.2. Patient Experience & Feedback

Enclosed *Janette Keenan*

Assurance

Item 11.2 - SBAR Patient Experience & Feedback.pdf (6 pages)
Item 11.2 - Appendix 1 Patient Experience & Feedback Annual Report 2023-24.pdf (25 pages)

11.3. The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions

Enclosed *Janette Keenan*

Assurance

Item 11.3 - SBAR The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions.pdf (4 pages)
Item 11.3 - Appendix 1 NHS Complaints Data Template 2023-25.pdf (4 pages)

12:15 - 12:25
10 min

12. PROFESSIONAL STANDARDS

12.1. Advanced Practitioners Review Update

Enclosed *Janette Keenan*

Assurance

Item 12.1 - SBAR Advanced Practitioners Review Update.pdf (5 pages)

12.2. Allied Health Professional Assurance Framework Update

Enclosed *Janette Keenan*

Assurance

- Item 12.2 - SBAR Allied Health Professional Assurance Framework Update.pdf (5 pages)

12:25 - 12:40
15 min

13. ANNUAL REPORTS / OTHER REPORTS

13.1. Care Opinion Annual Report 2023/24

Enclosed *Janette Keenan*

- Item 13.1 - SBAR Care Opinion Feedback Annual Report.pdf (7 pages)

13.2. Controlled Drug Accountable Officer Annual Report 2023/24

Enclosed *Fiona Forrest*

Assurance

- Item 13.2 - SBAR Controlled Drug Accountable Officer Annual Report 2023-24.pdf (3 pages)
- Item 13.2 - Appendix 1 Controlled Drug Accountable Officer Annual Report 2023-24.pdf (19 pages)

13.3. Review of Deaths of Children & Young People Annual Report 2023/24

Enclosed *Janette Keenan*

Assurance

- Item 13.3 - SBAR Review of Deaths of Children & Young People Annual Report 2023-24.pdf (3 pages)
- Item 13.3 - Appendix 1 NHS Fife Partnership Child Death Review Annual Report.pdf (16 pages)

12:40 - 12:45
5 min

14. LINKED COMMITTEE MINUTES

14.1. Area Clinical Forum held on 1 August 2024 (unconfirmed)

Enclosed

- Item 14.1 - Minute Cover Paper.pdf (1 pages)
- Item 14.1 - Area Clinical Forum Minutes (unconfirmed) 20240801.pdf (4 pages)

14.2. Area Medical Committee held on 11 June 2024 (confirmed)

Enclosed

- Item 14.2 - Minute Cover Paper.pdf (1 pages)
- Item 14.2 - Area Medical Committee Minutes (confirmed) 20240611.pdf (7 pages)

14.3. Area Radiation Protection Committee held on 9 May 2024 (unconfirmed)

Enclosed

- Item 14.3 - Minute Cover Paper.pdf (1 pages)
- Item 14.3 - Area Radiation Protection Committee (unconfirmed) 20240509.pdf (5 pages)

14.4. Clinical Governance Oversight Group held on 20 August 2024 (unconfirmed)

Enclosed

- Item 14.4 - Minute Cover Paper.pdf (1 pages)
- Item 14.4 - Clinical Governance Oversight Minutes (unconfirmed) 20240820.pdf (12 pages)

14.5. Fife Area Drugs & Therapeutic Committee held on 19 June 2024 (unconfirmed)

Enclosed

- Item 14.5 - Minute Cover Paper.pdf (1 pages)
- Item 14.5 - Fife Area Drugs & Therapeutic Committee Minutes (unconfirmed) 20240619.pdf (7 pages)

14.6. Fife IJB Quality & Communities Committee held on 5 July 2024 (unconfirmed)

Enclosed

- Item 14.6 - Minute Cover Paper.pdf (1 pages)
- Item 14.6 - Fife IJB Quality & Communities Committee Minutes (unconfirmed) 20240705.pdf (10 pages)

14.7. Infection Control Committee held on 7 August 2024 (unconfirmed)

Enclosed

- Item 14.7 - Minute Cover Paper.pdf (1 pages)
- Item 14.7 - Infection Control Committee Minutes (unconfirmed) 20240807.pdf (4 pages)

14.8. Medical Devices held on 12 June 2024 (unconfirmed)

Enclosed

- Item 14.8 - Minute Cover Paper.pdf (1 pages)
- Item 14.8 - Medical Devices Minutes (unconfirmed) 20240612.pdf (9 pages)

14.9. Medical & Dental Professional Standards Oversight Group held on 9 July 2024 (unconfirmed)

Enclosed

- Item 14.9 - Minute Cover Paper.pdf (1 pages)
- Item 14.9 - Medical & Dental Professional Standards Oversight Group Minutes (unconfirmed) 20240709.pdf (4 pages)

14.10. Resilience Forum held on 13 June 2024 (unconfirmed)

Enclosed

- Item 14.10 - Minute Cover Paper.pdf (1 pages)
- Item 14.10 - Resilience Forum Minutes (unconfirmed) 20240613.pdf (8 pages)

12:45 - 12:45
0 min

15. ESCALATION OF ISSUES TO NHS FIFE BOARD

15.1. To the Board in the IPQR Summary

Verbal *Arlene Wood*

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

Verbal *Arlene Wood*

12:45 - 12:45
0 min

16. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR’S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 25 SEPTEMBER 2024

12:45 - 12:45
0 min

17. ANY OTHER BUSINESS

12:45 - 12:45
0 min

18. Date of Next Meeting: Friday 1 November 2024 from 10am – 1pm via MS Teams

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 12 JULY 2024 AT 10AM VIA MS TEAMS

Present:
Arlene Wood, Non-Executive Member (Chair)
Colin Grieve, Non-Executive Member
Anne Haston, Non-Executive Member
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Joy Tomlinson, Director of Public Health *(part)*

In Attendance:
Jo Bennett, Non-Executive Member *(observing)*
Gemma Couser, Associate Director of Quality & Clinical Governance
Susan Fraser, Associate Director of Planning & Performance
Ben Hannan, Director of Reform & Transformation
Helen Hellewell, Deputy Medical Director, Health & Social Care Partnership (HSCP) *(part)*
Jocelyn Lyall, Chief Internal Auditor *(items 1 – 5 only)*
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Dr Iain MacLeod, Deputy Medical Director, Acute Services Division
Fiona McKay, Interim Director of Health & Social Care *(deputising for Nicky Connor)*
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting, and extended a warm welcome to Jo Bennett, a new Non-Executive Member of the Board, who is observing today's meeting, prior to joining as a committee member from 1 August 2024.

A warm welcome was also extended to Fiona McKay, who is replacing Nicky Connor as a regular attendee, in her new role as Interim Director of Fife Health & Social Care.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the meeting is being recorded to aid production of the minutes.

1. Apologies for Absence

Apologies were received from members Sinead Braiden (Non-Executive Member), Kirstie Macdonald, (Non-Executive Whistleblowing Champion), Aileen Lawrie (Area Clinical Forum Representative), Liam Mackie (Area Partnership Forum Representative), Carol Potter (Chief Executive) and routine attendees Nicky Connor (Director of Health & Social Care), Claire Dobson (Director of Acute Services), Fiona Forrest (Acting Director of Pharmacy & Medicines), Alistair Graham (Director of Digital & Information), Neil McCormick (Director of Property & Asset Management), Kirsty McGregor (Director of Communications), Margo McGurk (Director of Finance &

Strategy) and Dr Shirley-Anne Savage (Associate Director for Risk & Professional Standards).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 3 May 2024

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

4. Matters Arising / Action List

The Committee noted the updates and also the closed items on the Action List. It was agreed to keep action no. 8 open, with an extended deadline date of September 2024, to take into account the work that is underway in relation to significant adverse event reviews.

Action: Board Committee Support Officer

4.1 Adverse Event Process for Drug-Related Deaths

The Medical Director introduced the verbal update on the process for current adverse events for drug-related deaths.

It was reported that there are two different processes: NHS adverse event process, and the multi-disciplinary approach that is managed through the Health & Social Care Partnership. Assurance was provided that cases are monitored through the governance process within the Health & Social Care Partnership. It was advised that a plan has been put in place to address case reviews that are outstanding, which includes understanding the themes and exploring how services can be improved upon to avoid drug related deaths, and to take on lessons learned. It was also advised that discussions are ongoing at both local and national levels, for a joined-up approach.

The Committee agreed that a written update be provided at the next meeting to include reporting and escalation structures and review processes.

Action: Medical Director

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

5. ACTIVE OR EMERGING ISSUES

There were no active or emerging issues to be discussed.

6. GOVERNANCE MATTERS

6.1 Internal Audit Annual Report 2023/24

The Chief Internal Auditor was welcomed to the meeting and spoke to the report. It was advised that the Audit & Risk Committee considered the report as part of their wider portfolio of year-end governance assurance, and that the report is being presented to all the July Standing Governance Committees for information, particularly on the audit opinion related to each Committee's remit area.

It was highlighted that the report provides an overall significant level of assurance that there are effective and adequate internal controls in place within NHS Fife. Agreement has been made to address two internal controls that have been assessed as moderate and one that merits attention. The Chief Internal Auditor's opinion is provided within the report. It was advised that context has been provided on the internal and external environment, and that the report focuses on improvement work and delivering savings. An overview was provided on the clinical governance aspects of the report.

An update was provided on the recommendations from the previous Internal Control Evaluation report, with it being advised that steady progress is being made, with some slippage. An overview was provided on the current follow-up position. It was confirmed that agreement was made at the Public Health & Wellbeing Committee on 1 July 2024, that future iterations of the Internal Control Evaluation Report and Annual Report, will include a section on population health & wellbeing as related to its area of remit, and that specific audits will be included within the Internal Audit Plan for 2024/25.

The Associate Director of Quality & Clinical Governance agreed to cross reference the clinical governance elements of the report with the committee work plan and also the Clinical Governance Oversight Group work plan, to ensure that all clinical governance actions are incorporated.

Action: Associate Director of Quality & Clinical Governance

The Medical Director highlighted the significant improvements and developments and congratulated everyone for all their hard work.

The Committee took a **"significant" level of assurance** from the report.

6.2 Clinical Governance Oversight Group Assurance Summary from 18 June 2024 Meeting

The Associate Director of Quality & Clinical Governance reported that levels of assurance will be added to the report going forward. An overview was provided on the key matters from the summary, including the improvement actions for adverse events; an update that was provided to the group from the Health & Social Care Partnership and Acute Services Division; and the quarterly deteriorating patients report.

Following a question, it was advised that the adverse events trigger list was presented and approved in April 2024, and that the trigger list is aligned to the national framework. It was noted that the improvement plan was presented to the Clinical Governance Oversight Group in June 2024. It was agreed an update on progress against the overall improvement plan will be provided to the Committee towards the end of the year along with an overview of the adverse event trigger list and reporting schedule. A summary report reflecting National Audits outlined in our Clinical Governance Framework will also be developed to provide assurances to the Clinical Governance Oversight Group and to the Clinical Governance Committee.

Action: Associate Director of Quality & Clinical Governance

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

6.3 Corporate Risks Aligned to Clinical Governance Committee

The Medical Director reported that there were no significant changes, and no movement, in relation to any of the risks aligned to the Committee.

In terms of the Optimal Clinical Outcome risk, it was highlighted that a Committee Development Session was held on this risk, and that an update is expected to be presented to the Committee in September 2024, once the Risk & Opportunities Group have had an opportunity to review and revise this risk. It was noted that significant changes are expected, in particular, how effective the larger programmes of work are in mitigating the risk and how some of the performance metrics impact upon quality and safety, for example, waiting times.

It was reported that further work is required in relation to the Organisation Learning Group and that increased levels of assurance on how that group functions and improves quality & safety was required. It was advised that further detail on the work of the group will be included in future iterations of the report.

Potential new risks for pandemic preparedness and biological threats were reported, and it was advised that work is ongoing for developing those risks, and that consideration is being given to mirror the direction that the National Risk Register takes forward. It was noted that early indication is that these risks would sit under the Public Health & Wellbeing Committee.

In terms of the Digital and Information risk, it was agreed to include the clinical implications of the risk and impact of changes to digital programmes within the risk report.

The Cyber Resilience risks to include the risk mitigation within the update.

The Medical Director agreed to take forward with the Director of Digital & Information.

Action: Medical Director

It was agreed to recommend to the NHS Fife Board, to move the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to an operational risk, given that it is well managed.

Action: Medical Director

It was questioned how the clinical aspects of the corporate risks that sit within the Finance, Performance & Resources Committee are aligned to the Clinical Governance Committee in terms of the clinical risk consequences. Members supported those risks being presented to this Committee on a yearly basis, for assurance on the clinical aspects.

Action: Medical Director/Board Committee Support Officer

Following concern around the level of assurances for each of the risks, it was agreed that the clinical impact on performance of the risk mitigation be brought back to Committee, through the Committee workplan.

Action: Medical Director/Associate Director of Quality & Clinical Governance

The Committee took a **"moderate" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.

6.4 Delivery of Annual Workplan 2024/25

It was agreed to add 'Patient Story' to each meeting of the Committee, as opposed to an ad-hoc item.

Action: Board Committee Support Officer

It was agreed to add the Reform, Transform, Perform workstreams to the Committee workplan, following discussion with the Chair, Medical Director, Associate Director of Quality & Clinical Governance and Director of Reform & Transformation and further discussion at the Board at the end of the month.

Action: Medical Director/Board Committee Support Officer

The Committee took **assurance** from the tracked workplan and **agreed** to add any outstanding actions from the internal audit report.

7. STRATEGY / PLANNING

7.1 Corporate Objectives 2024/25

The Medical Director reported that the corporate objectives have been agreed and developed through the Executive Directors' Group and Associate Director of Culture & Development. It was advised that the corporate objectives have been aligned to the Reform, Transform, Perform programme and the Population Health & Wellbeing Strategy.

It was reported that the corporate objectives had been considered at the recent Remuneration Committee and are being presented to the Standing Governance Committees before formal sign off by NHS Fife Board in July 2024. It was noted that individual Directors' personal objectives will also be presented to the Remuneration Committee.

The Committee took a **"significant" level of assurance** that the Corporate Objectives 2024/25 capture the priority actions for NHS Fife aligned to the Population Health & Wellbeing Strategy and Reform, Transform & Perform Framework.

7.2 Letter from the Scottish Government: Reforming Services and Reforming the Way We Work

The Medical Director advised that the appendix to the letter describes the strategic intent to reform Scotland's NHS, and that collaboration and discussion at various Director levels across Scotland has been undertaken in relation to reforming the way we work.

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

7.3 Annual Delivery Plan Scottish Government Response 2024/25

The Associate Director of Planning & Performance reported that the Annual Delivery Plan was submitted to the Scottish Government on 24 March 2024, and subsequently, feedback was received on 8 May 2024, advising that the Scottish Government were satisfied that NHS Fife broadly meet the requirements for the Medium-Term Annual Delivery Plan.

It was explained that there is, at present, a limited level of assurance relating to uncertainty over the delivery of the Annual Delivery Plan actions in the current financial circumstances. The Quarter 1 Annual Delivery Plan report will clarify the position of these actions and the Reform, Transform and Perform actions will be included in this update.

The Committee took a **"limited" level of assurance** from the paper.

7.4 Annual Delivery Plan 2023/24 Quarter 4 Report

The Associate Director of Planning & Performance advised that the report reflects the progress made against each of the Annual Delivery Plan recovery drivers, the actions that were completed in 2023/24, actions that were still on track to be delivered, those at risk of not being delivered and those expected not to be delivered. It was highlighted that there were a number of actions at risk, of not being completed, relating to Quality & Care: Primary Care & Community; Urgent Care & improving flow in Victoria Hospital, pathways around prostate & bladder cancer; and the implementation of Hospital Electronic Prescribing & Medicines Administration (HEMPA).

Assurance was provided that any outstanding actions are carried forward, and that any risks which would change our corporate risks, would be raised with the Committee as an exception. It was advised that performance risks will be highlighted to the Committee in future iterations of the report.

The Committee noted that the Annual Delivery Plan Quarter 4 update provides the status of Annual Delivery Plan actions for the year 2023/24 and provides a **"moderate" level of assurance**.

7.5 Clinical Governance Strategic Framework Delivery Plan 2024/25

The Associate Director of Quality & Clinical Governance advised that the plan for 2024/25 contains specific actions to deliver the Clinical Governance Strategic Framework, and that any new and emerging priorities will be added. It was reported that varying levels of assurance are aligned to the various programmes stated within the delivery plan. A refresh of the strategic framework will commence in September 2024, and will involve a range of engagement across the organisation.

Discussion followed, and suggestion was made for flash reports to be provided to the Committee, to provide assurance on the position of the audits being carried out in relation to quality & safety. An explanation was provided on the significant issues that would be escalated to the Committee, and it was noted that the process for escalation and tracking progress of the framework, and the national clinical audits, is included within the strategic framework. The role of the Clinical Governance Oversight Group and Clinical Governance Committee in terms of the requirements from the Health & Social Care Partnership's perspective around quality & safety was highlighted, and it

was agreed that a discussion would take place with the Chair, outwith the meeting, on clear escalation and reporting to Committee.

Action: Medical Director/Associate Director of Quality & Clinical Governance

The Associate Director of Quality & Clinical Governance agreed to review the quality & improvement training aspects for the next iteration of the delivery plan. It was advised that the delivery plan does not cover all aspects of the strategic framework, and that the plan has been devised to ensure it is achievable with prioritised actions.

The Chair commended the Clinical Governance Strategic Framework Delivery Plan 2024/25.

The Committee took a **"moderate" level of assurance** from the delivery plan.

8. QUALITY / PERFORMANCE

8.1 Integrated Performance & Quality Report

The Director of Nursing provided an update on the clinical governance aspects of the report. It was noted that pressure ulcers have been the most reported incident, followed by cardiac arrests and in-patient falls. It was reported that work is underway through two delivery groups within Acute Services and the Health & Social Care Partnership, to review performance and improvement initiatives in relation to in-patient falls.

In terms of major or extreme adverse events, it was reported that the Significant Adverse Events Review panel's sign-off structure has provided an opportunity to identify thematics.

It was advised that the Ward of the Week programme has provided a continuous focus on pressure ulcers, through enhanced education, dedicated review time, and the trial of new pressure reducing equipment. It was reported that there has been a significant improvement across the orthopaedic ward. It was further reported that our Allied Health Professionals are actively supporting the completion of the skin bundle, which is presenting positive outcomes.

It was reported that the Health & Social Care Partnership are developing their Tissue Viability Group and are working closely with district nurses to complete a number of quality improvement projects.

A new national tool that is being piloted around the quality of care review and care assurance visits, was also noted.

The Director of Nursing also highlighted that NHS Fife was in upper quartile benchmark for CDI, ECB and SAB.

The Associate Director of Quality & Clinical Governance agreed to provide an updated position in the next iteration of the report, relating to using a Red, Amber, Green (RAG) status for numbers of major extreme adverse events. Members noted that the RAG statuses for this metric were not helpful. Also, it was agreed that information relating to the major/extreme adverse events categorised as 'other' will be provided at the next meeting.

Action: Associate Director of Quality & Clinical Governance

The implications of not closing extreme adverse events were raised, and an explanation was provided on the challenges of closing these events on the system, with it noted that improvement actions have been put in place for ensuring that extreme adverse events are followed up and closed off in a timely manner.

The Chair requested further detail around mental health incidents in terms of the most common themes. A further request was made for the detail around the reducing restrictive practice improvement work and the impact this work has on use of restraint, physical violence and self-harm.

Action: Interim Director of Health & Social Care

The Committee took a **"moderate" level of assurance** and examined and considered the NHS Fife performance as summarised in the IPQR.

8.2 Healthcare Associated Infection Report

The Director of Nursing spoke to the report and noted that surgical site infections surveillance is currently still paused. An update was provided on the outbreak of infection data and the cleaning & healthcare environment, and it was also noted that there had been no further hospital inspections since the last Committee meeting.

A comment was made in relation to not being fully assured on the data around hand hygiene, and it was advised that work is underway to explore an electronic system. Meantime, LANQIP is available for wards/departments to enter their monthly compliance data, following hand hygiene audits. The Director of Nursing highlighted that any infection prevention and control issues, for example SAB, would also trigger a review of hand hygiene in the service area.

In terms of the cleaning & healthcare environment data remaining consistently high, it was reported that this area is internally validated, with individual actions taken. It was also noted that there are various elements that are looked at during the audit process. It was reported that the Infection, Prevention & Control Team have no outstanding concerns, and that the improvement work being carried out is positive. The Director of Nursing agreed to provide further detail on how the audits are carried out, for the next Committee meeting.

Action: Director of Nursing

Following a question, the Director of Nursing advised that as part of outbreak reporting, COVID-19 associated deaths are reported to Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland and are also summarised in the National Records of Scotland.

The Committee took a **"moderate" level of assurance** from the report.

8.3 Ionising Radiation (Medical Exposure) Regulations Inspection Report 2024

The Medical Director advised that the Ionising Radiation (Medical Exposure) Regulations Inspection Report 2024 was not included within the papers, and will be circulated after the meeting.

It was reported that Healthcare Improvement Scotland (HIS) carried out an inspection in relation to our nuclear medicine facilities, and that the outcome was very positive, with it being noted that the facilities were assessed as being of extremely high quality. An overview was provided on the two recommendations from the inspection. It was advised that audits are carried out at service level and then reported to the Ionising Radiation (Medical Exposure) Regulations Board.

The Committee took a **"significant" level of assurance** from the contents of the HIS IR(ME)R inspection report as reassurance that appropriate governance is in place for managing the use of radioisotopes in NHS Fife.

8.4 Neonatal Mortality Review Response

The Director of Nursing advised that the report had been reviewed by the Women and Childrens Clinical Governance Committee and escalated to the Acute Services Clinical Governance Committee and also the Clinical Governance Oversight Group, prior to submission to the Clinical Governance Committee. The report is from MBRRACE-UK: Mothers and Babies Reducing Risk through Audits and Confidential Enquiries and is a surveillance report for births in 2022.

Questions were raised around deprivation, ethnicity and racial bias and it was agreed further information be provided outwith the meeting.

Action: Director of Nursing

The Medical Director advised that a further HIS report relating to Neonatal Mortality Review will be presented to the next Committee meeting.

Action: Medical Director / Board Committee Support Officer

The Committee took a **"significant" level of assurance** from the paper.

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1 Patient Story

The Director of Nursing presented on a patient's story in relation to organ donation.

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

9.2 Patient Experience & Feedback Report

The Director of Nursing reported that the new patient experience dashboard and new weekly reporting format provides a deeper level of detail, which supports services to manage the complaints process. It was noted that work is being carried out to further enhance the dashboard.

An overview was provided on the complaints position, and it was noted that there had been some delays in responding to stage one complaints, due to staff absence within the Patient Experience Team, and that those complaints were escalated to stage two. It was advised that all services engage in weekly meetings with the Patient Experience Team to review open complaints and explore new ways of working, and that a more detailed meeting takes place on a monthly basis with Acute Services to review delayed responses to complaints and quality improvement initiatives within the

service. It was highlighted that NHS Fife is one of the top performing Health Boards in terms of the care opinion work.

An overview was provided on the work that is underway to ensure that staff absence does not affect the timing of responding to complaints, resulting in complaints moving from a stage one to a stage two.

An explanation was provided on the complexity scoring tool, and the Director of Nursing agreed to take forward with the team, more detail on complaints that have been identified through the complexity scoring tool as taking an extreme length of time to respond to.

Action: Director of Nursing

A question was raised regarding the 17 complaints with SPSO and if this was in part related to the challenges in responding to and putting things right for people who have reason to complain. It was advised that complaints that are escalated to the Scottish Public Services Ombudsman are often returned with no further action required. The Director of Nursing agreed to provide more information in the quarterly reports.

Action: Director of Nursing

It was agreed that consideration be given to providing the Staff Governance Committee with elements of the reports, in terms of the staffing issues.

Action: Director of Nursing

The Chair acknowledged all the hard work the teams across the service provide.

The Committee took a **"limited" level of assurance** from the report.

10. ANNUAL REPORTS / OTHER REPORTS

10.1 Clinical Advisory Panel Annual Report 2023/24

The Medical Director provided an overview on the contents of the report and explained that there has been a significant financial increase, mainly in relation to outsourcing mental health patients.

The Committee took a **"significant" level of assurance** that a fair and transparent process is adopted across NHS Fife to consider requests for exceptional, high cost and very specialist referrals for individual patients and out of area referrals.

10.2 Fife Child Protection Annual Report 2023/24

The Director of Nursing advised that the Fife Child Protection Annual Report for 2023/24 was also presented to the Public Health & Wellbeing Committee at their July 2024 meeting. An overview was provided on the contents of the report, and it was advised that the report outlines performance and reflections on the continued work to improve services, particularly due to the changing landscape over the previous year to prepare for the changes to the child protection in Scotland national guidance.

The Committee took a **"moderate" level of assurance** from the report.

10.3 Radiation Protection Annual Report 2023/24

The Medical Director advised that the report details all the activity to ensure that safe and high quality standards are maintained in relation to ionising radiation. It was noted that close working is carried out with the Radiation Protection Advisors, Medical Physics experts and Senior Managers in each area that use ionising radiation. An overview was provided on the contents of the report.

The Medical Director agreed to clarify outwith the meeting the recommendation to justify the use of different activities to those detailed in the Administration of Radioactive Substances Advisory Committee (ARSAC) Notes for Guidance, under the Ionising Radiation (Medical Exposure) Regulations section of the report.

Action: Medical Director

The Committee took a **"significant" level of assurance** from the contents of the Radiation Annual report that appropriate governance is in place for managing the use of ionising radiation in NHS Fife.

10.4 Transport of Medicines Audit Report

The Committee **noted** the **"reasonable" assurance** audit opinion following the internal audit of this area.

10.5 Medicines Assurance Audit Programme Short Life Working Group Audit Report

The Committee **noted** the report and the input from internal audit in devising the programme of audit.

11. LINKED COMMITTEE MINUTES

The Committee **noted** the linked committee minutes and the escalations to the Committee.

11.1 Area Medical Committee held on 9 April 2024 (unconfirmed)

11.2 Area Radiation Protection Committee held on 9 May 2024 (unconfirmed)

11.3 Cancer Governance & Strategy Group held on 21 March 2024 (confirmed) & 30 May 2024 (unconfirmed)

The Committee **noted** that an SBAR will be presented to a future meeting of the Committee on the rapid cancer diagnostics services. The Board Committee Support Officer to add to the workplan.

Action: Board Committee Support Officer

11.4 Clinical Governance Oversight Group held on 18 June 2024 (unconfirmed)

11.5 Digital & Information Board held on 9 May 2024 (unconfirmed)

The Committee **noted** that a briefing on the NHS Dumfries and Galloway cyber incident will be presented to the Committee at a future meeting. The Board Committee Support Officer to add to the workplan.

Action: Board Committee Support Officer

11.6 Fife IJB Quality & Communities Committee held on 8 March 2024 (confirmed) & 10 May 2024 (unconfirmed)

11.7 Health & Safety Subcommittee held on 7 June 2024 (unconfirmed)

11.8 Infection Control Committee held on 5 June 2024 (unconfirmed)

11.9 Medical & Dental Professional Standards Oversight Group held on 11 June 2024 (unconfirmed)

11.10 Research, Innovation & Knowledge Oversight Group held on 14 May 2024 (unconfirmed)

11.11 Resilience Forum held on 13 March 2024 (unconfirmed)

The Committee **noted** that the Health Emergency Preparedness, Resilience & Response (EPRR) Training & Exercise plan for 2024/25 is to be shared with Clinical Governance Committee. The Board Committee Support Officer to add to the workplan.

Action: Board Committee Support Officer

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1 To the Board in the IPQR Summary

There were no performance related issues to escalate to the Board.

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

It was agreed to escalate the corporate risks aligned to the Clinical Governance Committee, in terms of further actions. It was also agreed to escalate that a limited level of assurance was taken from the Committee around complaints, and that NHS Fife is one of the top performing Health Boards around care opinion.

13. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 30 JULY 2024

The reflections from the meeting & agreement of matters will be considered by the Chair for onward submission to NHS Fife Board. The report will be provided to the following Committee meeting for information.

14. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting – Friday 6 September 2024 from 10am – 1pm via MS Teams

Meeting: **Clinical Governance Committee**

Meeting date: **12 July 2024**

Title: **Committee Chair's Assurance Report**

1. Committee's Performance against Annual Workplan

The Committee reviewed the work plan for the financial year 2024/25. A number of planned items have been deferred and rescheduled to the September 2024 meeting:

- Digital and Information Strategy 2019-24 Update.
- Adult Support & Protection Annual Report 2020-22.
- Medical Devices Update.
- Organisational Learning Update.
- Internal Audit Clinical Governance recommendations to be added

2. Matters Arising

A verbal update was provided to the Committee relating to the Adverse Event Review Process for Drug-Related Deaths and it was agreed that a written update will be provided at the September 2024 meeting to include reporting and escalation structures and process.

3. The Committee considered the following items of business:

3.1 Governance

- **Internal Audit Report**
  The committee noted the internal audit opinion and that the Board has adequate and effective controls in place. The discussion focused upon the Clinical Governance elements of the report and a number of actions required in response to the recommendations. It was agreed that the Associate Director of Quality and Clinical Governance will ensure that all CG related actions are incorporated into our annual workplan.

- **Clinical Governance Oversight Group Assurance Summary**
  The report was discussed, and further information will be provided to the Committee relating to the ongoing improvement work associated with adverse event trigger list, cardiac arrest and the deteriorating patient.

- **Corporate Risks Aligned to CGC**
  There are 5 corporate risks aligned to the CGC. There are no new risks. The Committee agreed a moderate level of assurance with respect to mitigation of the risks, however acknowledged there were varying levels of assurance across each of the risks. Following discussion at the meeting a number of actions were agreed as highlighted in the minute of the meeting to strengthen assurance and establish how well the controls are working.

No.	Risk	Actions Required
5	Optimal Clinical Outcomes	Revise risk. Provide information relating to the effectiveness of the risk mitigation. Clinical impact of waiting times.
9	Quality and Safety	Organisational Learning Plan
6	Off Site Area Sterilisation and	Recommend to the Board, to move the

	Disinfection Unit Service	'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to an operational risk register
17	Cyber Resilience	Risk mitigation actions to be provided along with update
18	Digital and Information	Clinical implication of the risk to be provided and impact of changes to digital programmes

3.2 Strategy and Planning

- **Clinical Governance Strategic Framework Delivery Plan**
  The Committee commended the comprehensive plan and requested that consideration be given to a reporting method for National Clinical Audits included in our Clinical Governance Strategic Framework and noted the planning for the framework review required 2025.

3.3 Quality and Performance

- **IPQR**
  The IPQR was reviewed and discussed; there were no performance related issues for escalation to the Board. Noted new mental health indicators and further information requested around mental health adverse event themes. Information to be provided to next CGC regarding major extreme adverse events categorised as other.

- **HAIRT**
  The HAIRT report was reviewed and discussed. There were no infection and prevention control issues for escalation to the Board. Director of Nursing highlighted that NHS Fife was in upper quartile benchmark for CDI, ECB and SAB.

- **Ionising Radiation**
  The report provided an overview of the HIS Announced Inspection undertaken February 2024; Ionising Radiation (Medical Exposure) Regulations 2017. Outcome of the inspection was no requirements and two recommendations providing significant assurance of robust control.

- **Neonatal Mortality Review Response**
  The report provided an overview of stillbirths and neonatal deaths of babies born in Fife in 2022. This is an annual report and it was noted that mortality rates for Fife are similar to or lower than those seen across similar Trusts and Health Boards. A further Health Improvement Scotland report relating to Neonatal Mortality Review will be presented to the next committee meeting.

3.4 Person Centred Care / Participation and Engagement

- **Patient Experience and Feedback Report**
  The Committee acknowledged the ongoing work to support improvements to the complaints handling process. Despite this the committee agreed a limited level of assurance due to the ongoing challenges in responding to both Stage 1 and 2 complaints. Further information requested for next CGC meeting relating to SPSO cases and assurances around completion of action plans. Of note NHS Fife is one of the top performing Health Boards in terms of the care opinion work.

4. Annual /Other Reports

There were two annual reports 2023/24 presented for **assurance**:

Fife Child Protection Annual Report (moderate assurance)
Radiation Protection Annual Report (Significant assurance)

There were two audit reports provided for **information**:

Transport of medicines
Medicines assurance audit programme

5. Delegated Decisions taken by the Committee

Nil to report

6. Issues to Highlight to the Board

- There were no performance-related matters to escalate to the Board.
- NHS Fife is one of the top performing Health Boards in terms of the care opinion work.
- It was agreed to escalate to the Board the corporate risks aligned to the Clinical Governance Committee, to highlight further actions.
- It was agreed to escalate to the Board that a limited level of assurance was taken from the Committee around complaints and feedback.
- The significant improvements and developments in relation to the Annual Internal Audit Report was congratulated and everyone thanked for all their hard work.

Arlene Wood
Chair
Clinical Governance Committee

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
1.	12/07/24	**Integrated Performance & Quality Report**	To provide an updated position in the next iteration of the report, relating to using a RAG status for numbers of major extreme adverse events.	**GC**	It is recommended that the RAG status for numbers of adverse events is removed. **DECISION REQUIRED.**	September 2024
2.	12/07/24	**Integrated Performance & Quality Report**	To provide further detail around mental health incidents in terms of the most common themes.	**FM**		September 2024
3.	12/07/24		To provide the detail around the reducing restrictive practice improvement work and the impact this work has on use of restraint, physical violence and self-harm.	**FM**		September 2024
4.	12/07/24	**Delivery of Annual Workplan**	To add the Reform, Transform, Perform workstreams to the Committee workplan, following discussion with the Chair, Medical Director, Associate Director of Quality & Clinical Governance and Director of Reform & Transformation and further discussion at the Board.	**CM/HT**	The Acute Services Redesign Programme to report via the Clinical Governance Committee, with the first report on the agenda for the September 2024 meeting.	September 2024
5.	12/07/24	**Internal Audit Annual Report 2023/24**	To cross reference the clinical governance elements of the report with the committee workplan and also the Clinical Governance Oversight Group workplan, to ensure that all clinical governance actions are incorporated.	**GC**	Deadline not reached. CGOG Annual Statement of Assurance for 2024/25 should include reference to the assurance it receives on inspections by external bodies such as Healthcare Improvement Scotland and the Mental Welfare Commission - to be added to CGOG workplan.	October 2024

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CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
6.	12/07/24	**Corporate Risks Aligned to Clinical Governance Committee -** *Off-Site Area Sterilisation and Disinfection Unit Service*	To recommend to the NHS Fife Board, to move the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to an operational risk.	**SAS**	Corporate Risk Register not scheduled to be considered by the Board until November 2024.	November 2024
7.	12/01/24	**Medical Appraisal and Revalidation Annual Report 2022/23**	To provide narrative around performance for revalidation, in the next report.	**CM**	Deadline not reached.	November 2024
8.	12/07/24	**Clinical Governance Oversight Group Assurance Summary from 18 June 2024 Meeting – Adverse Events**	To provide an update, towards to the end of the year, on progress against the overall adverse events improvement plan, along with an overview of the adverse event trigger list and reporting schedule	**GC**	Deadline not reached.	November 2024
9.	12/07/24	**Delivery of Annual Workplan**	To add to the workplan, that an SBAR will be presented to a future meeting of the Committee on the rapid cancer diagnostics services.	**HT**	Complete.	September 2024
10.	12/07/24		To add to the workplan, that a briefing on the NHS Dumfries and Galloway cyber incident will be presented to the Committee at a future meeting.	**HT**	Complete.	September 2024
11.	12/07/24		To add to the workplan, that the Health Emergency Preparedness, Resilience & Response (EPRR) Training & Exercise plan for 2024/25 is to be shared with Clinical Governance Committee.	**HT**	Complete.	September 2024

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CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
12.	12/07/24	**Delivery of Annual Workplan**	To add 'Patient Story' to each meeting of the Committee.	**HT**	Complete	September 2024
13.	12/07/24	**Healthcare Associated Infection Report**	To provide further detail around the cleaning & healthcare environment audits, and how these are carried out.	**JK**	JK issued email on 25 July 2024, with further detail. Action complete.	September 2024
14.	12/07/24	**Neonatal Mortality Review Response**	To provide further information to members, around deprivation, ethnicity and racial bias, outwith the meeting.	**JK**	AL confirmed via email on 22 July 2024, that this action is complete.	September 2024
15.	12/07/24	**Neonatal Mortality Review Response**	A further Health Improvement Scotland report relating to Neonatal Mortality Review to be presented to the next Committee meeting.	**CM/HT**	Complete - on agenda.	September 2024
16.	03/05/24	**Area Clinical Forum Annual Statement of Assurance 2023/24**	To discuss any work that could be undertaken to enhance clinical connections.	**AL**	AL is reaching out to various Chairs.	September 2024
17.	03/05/24	**Corporate Risks Aligned to Clinical Governance Committee –** *Optimal Clinical Outcomes*	To include timescales within the Optimal Clinical Outcomes review.	**SAS**	On agenda - will be included within the Corporate Risks paper.	September 2024
18.	12/07/24	**Radiation Protection Annual Report 2023/24**	To clarify outwith the meeting the recommendation to justify the use of different activities to those detailed in the Administration of Radioactive Substances Advisory Committee (ARSAC) Notes for Guidance, under the Ionising Radiation (Medical Exposure) Regulations section of the report.	**CM**	Complete.	September 2024

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CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
19.	12/07/24	**Clinical Governance Strategic Framework Delivery Plan 2024/25**	To discuss with the Chair, around clear escalations and reporting to the Committee in terms of the requirements from the Health & Social Care Partnership's perspective around quality & safety, and the roles of both the Committee and Clinical Governance Oversight Group in terms of those escalations.	**CM/GC**	GC has discussed with the Chair and agreed that the refresh of the NHS Fife Clinical Governance Strategic Framework will include an overview of what the delegated services within the HSCP will provide in terms of quality and safety assurance.	September 2024
20.	03/05/24	**Patient Experience & Feedback Quarter 4 Report**	To discuss with the Director of Nursing, the organisational learning work taking place in terms of thematic studies of complaints and to bring a high-level update back to the next meeting.	**GC**	The Organisational Learning Leadership Group are progressing work to create connections to learn across complaints, adverse events and legal claims. A bank of key words will be created for applying to complaints, legal claims and adverse events. This will help to identify cross cutting themes and opportunities for improvement.	September 2024
21.	03/05/24	**Integrated Performance & Quality Report**	An update to be provided to the Committee on the trigger list, which is part of the NHS Fife Adverse Events Policy, and to also identify if there are any recurring themes for those categorised as 'other' for the major or extreme category.	**JK**	The trigger list has been redefined and agreed at Clinical Governance Oversight Group. Work is underway to define local event specific reviews that will equate a SAER and provide assurance that the reporting, reviewing and governance of these locally agreed event specific review meets the standards as a level 1 review as detailed in the national framework.	September 2024

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	Closed

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
					In respect of "other clinical" adverse events it has been agreed at CGOG that this category will be redefined to give visibility to the precise type of event. Lead for Adverse Events presented to CGOG an analysis of "other clinical events" in 2023. Of the 68 SAERs which were commissioned in 2023 18 were categorised as "other clinical events". To allow the analysis of variation and identification of emergent issues, data was collected on all sub categories that sit under the other clinical events category that have been reported in the last 12 months, as major or extreme. A data over time chart was populated with the data from each sub category. Results across all the sub categories showed random variation with no shifts in data or single data points signalling an issue within the system. A positive emergence of the SAER panel sign off structure has been realised in the opportunity to identify themes. Assurance can be taken, that events within this category that have been review as a SAER will all be subjected to SAER panel sign off.	

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	Closed

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
22.	12/07/24	**Clinical Governance Oversight Group Assurance Summary from 18 June 2024 Meeting – Adverse Events**	A summary report reflecting National Audits outlined in our Clinical Governance Framework to also be developed to provide assurances to the Clinical Governance Oversight Group and to the Clinical Governance Committee.	**CG**	Refreshed NHS Fife Clinical Governance Strategic Framework will set out the local governance arrangements for providing assurance to CGC on key audit programmes. A high level summary report will be provided to CGC setting out status of each of audit programmes detailed in the framework.	September 2024
23.	12/01/24	**Reinforced Autoclaved Aerated Concrete (RAAC)**	To build into standard business continuity plans, the process and phases of work for deteriorating areas, including risk assessments, reporting, and relocating staff and patients.	**NM**	On agenda under matters arising.	September 2024
24.	12/07/24	**Corporate Risks Aligned to Clinical Governance Committee –** *Finance, Performance & Resources Risks*	To present to the Committee on a yearly basis, the clinical aspects of the corporate risks that sit within the Finance, Performance & Resources Committee and are aligned to the Clinical Governance Committee in terms of the clinical risk consequences.	**CM/HT**	The following risks have been added to the workplan: Cancer Waiting Times, Access to Outpatient Diagnostic and Treatment Services and Whole System Capacity.	September 2024
25.	12/07/24	**Adverse Event Process for Drug-Related Deaths**	To provide a written update at the next meeting to include reporting and escalation structures and review processes.	**CM**	On agenda.	September 2024
26.	12/07/24	**Patient Experience & Feedback Report**	To provide more detail on complaints that have been identified through the complexity scoring tool as taking an extreme length of time to respond to.	**JK**	Information will be added to future quarterly reports.	September 2024

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 6 September 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
27.	12/07/24	**Patient Experience & Feedback Report**	Further detail to be provided within the quarterly report, around complaints that are escalated to the Scottish Public Services Ombudsman.	**JK**	Will be actioned in future quarterly reports.	September 2024
28.	12/07/24	**Integrated Performance & Quality Report**	Information relating to the major/extreme adverse events categorised as 'other' to be provided at the next meeting.		It is anticipated that the following further changes will be made in advance of the next iteration of the IPQR: • Removal of number of actions required to meet target • QPI for finalising SAERs • Rename "Review and Learning from Adverse Events" • Include data on SAER outcome-focus initially on outcome 4 • Consideration to be given to give assurance in relation to emergent themes • Focus on improvement work	September 2024

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Reinforced Autoclaved Aerated Concrete (RAAC) Update**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Neil McCormick, Director of Property & Asset Management**

Executive Summary:

- All Blocks in our buildings have been assessed for the likelihood of containing RAAC.
- For those blocks meeting the criteria for further assessment, a desktop survey was carried out by external engineers/surveyors to categorise risk.
- All 29 blocks identified have now been surveyed.
- Of the 7 blocks where RAAC has been discovered, 4 blocks are stable and require annual monitoring to ensure no deterioration of the material and 3 areas require further attention.
- For the areas which require further attention, risk assessment have been undertaken and appropriate mitigations put in place.
- Scottish Government is in the process of developing guidance and are looking at a framework to provide external support for monitoring those buildings which contain RAAC.
- Over the long-term, the RAAC will either be replaced as part of ongoing maintenance or buildings will be withdrawn from use in line with the Whole Systems Infrastructure Plan.
- There is no immediate risk to patients, staff or visitors as the RAAC that has been discovered is stable or identified risks have been mitigated.
- Identified RAAC will be built into standard Business Continuity Plans for clinical services, if areas are found to be deteriorating, further risk assessments and mitigations will be carried out in conjunction with the local staff. It has not been determined necessary to relocate any staff or patients at this time.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Emerging issue

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Work is underway across Scotland to survey all NHS buildings which may potentially contain Reinforced Autoclaved Aerated Concrete (RAAC).

2.2 Background

RAAC is a lightweight form of concrete used mainly in roof, floor and wall construction in the UK during the second half of the 20th century. It has been found in a range of buildings, both in the public and private sector.

The material is known to be less durable than other forms of concrete, particularly where it has been damaged by water or where it was not formed correctly during the original fabrication. RAAC was used widely from the 1960's until it was phased out in the 1990's. NHS Scotland Assure (part of NHS National Services Scotland) are co-ordinating a programme of work to carry out discovery surveys of all properties across the NHS estate that have been identified as potentially containing RAAC. A list of all buildings being surveyed across the NHS Estate in Scotland has been published on the NHS National Service Scotland website Reinforced Autoclaved Aerated Concrete (RAAC) Discovery Survey Programme - List of Properties | National Services Scotland (nhs.scot).

Using assessment criteria provided by NHS Scotland Assure, NHS Fife has identified several buildings within our Estate which may potentially contain RAAC and has supplied this information to NHS Assure. This list of buildings identified was a desk-based exercise based primarily on when the buildings - or parts of buildings - were built. While it is likely that parts of some of our buildings will contain RAAC, we will only know definitively once more detailed surveys are carried out.

2.3 Assessment

We have identified 30 blocks (elements of buildings) within our estate that we have passed to the National Programme for further assessment. The criteria for identifying areas were agreed nationally and included the following questions:

1. Was the building, or any part of the building or extensions constructed between 1960 and 1989?

2. Is any part of the roof structure flat, or was previously flat (with a new pitched roof over)?

3. Is any part of the roof structure a low pitch (<45 degrees) long span sloped roof?

4. Is any part of the roof construction concrete?

A desktop survey is carried out if the answer to all questions is yes. The desktop survey identifies the risk of the block potentially containing RAAC based on the design information shared with the external partner employed by NSS (Currie & Brown).

Any of the blocks which are identified as high or medium risk of having RAAC have been physically surveyed by a Structural Engineer managed by the external partner (WSP). The blocks identified as low risk have now started to be surveyed.

Of the 30 blocks having been identified as being at a risk of containing RAAC, 29 of these blocks have been surveyed to date, with the final block being identified as derelict and unused and as such has now been removed from the programme.

Following the surveys (See Appendix 1 for an example), 22 blocks have had no RAAC discovered (see Table 1), 7 have discovered RAAC (see Table 2).

Site Name	Block Name	Likelihood Category	RAAC
Cupar Health Centre	Cupar Main Block	High Likelihood of RAAC	No
Kelty Health Centre	Kelty Main Block	High Likelihood of RAAC	No
Kinghorn Health Centre	Kinghorn Main Block	High Likelihood of RAAC	No
Leven Health Centre	Leven Main Block	Medium Likelihood of RAAC	No
Queen Margaret Hospital	Boiler House	Medium Likelihood of RAAC	No
Queen Margaret Hospital	Wards 5 to 7 ICASS	Medium Likelihood of RAAC	No
Queen Margaret Hospital	Wards 1 to 4	Medium Likelihood of RAAC	No
Randolph Wemyss Memorial Hospital	Kitchens, Boiler House, Wards 1 and 2	Low Likelihood of RAAC	No
Victoria Hospital	Kitchen and Dining Room	Medium Likelihood of RAAC	No
Victoria Hospital	Fife Area Labs North	High Likelihood of RAAC	No
Victoria Hospital	Hayfield House	High Likelihood of RAAC	No
Victoria Hospital	Phase 1 Main Building	High Likelihood of RAAC	No
Victoria Hospital	Phase 1 Basement to Lab Tunnel	Low Likelihood of RAAC	No
Victoria Hospital	Kitchen to Service Yard Tunnel	Low Likelihood of RAAC	No
Victoria Hospital	Central Laundry	Low Likelihood of RAAC	No
Whyteman’s Brae Hospital	Victoria Radio Network	Medium Likelihood of RAAC	No
Whyteman’s Brae Hospital	Boiler House	High Likelihood of RAAC	No
Whyteman’s Brae Hospital	Generator	High Likelihood of RAAC	No
Whyteman’s Brae Hospital	Day Hospital and Ravenscraig	High Likelihood of RAAC	No
Whyteman’s Brae Hospital	Day Hospital Entrance	High Likelihood of RAAC	No
Whyteman’s Brae Hospital	Ward Block	High Likelihood of RAAC	No

Table 1 - Blocks where RAAC has not been identified

Site Name	Block Name	Likelihood Category	RAAC
Kirkcaldy Health Centre	Kirkcaldy Main Block	High Likelihood of RAAC	Yes
Lynebank Hospital	Tayview and Ward 12 Offices	High Likelihood of RAAC	Yes
Lynebank Hospital	Psychology, Health Records and Health Storage	High Likelihood of RAAC	Yes
Lynebank Hospital	Main Building	High Likelihood of RAAC	Yes
Queen Margaret Hospital	Phase 1 Main Block	Medium Likelihood of RAAC	Yes
Adamson Hospital	Tarvit Ward	High Likelihood of RAAC	Yes
Glenrothes Hospital	Glenrothes Main Block	High Likelihood of RAAC	Yes

Table 2 - Blocks where RAAC has been identified

Site Name	Block Name	Likelihood Category	RAAC
Cameron Hospital	Linen Room Closed	Removed from Programme	n/a

Table 3 - Blocks which have not yet been surveyed

Where RAAC has been discovered (7 blocks) the blocks can be divided into 2 distinct categories:

- Blocks where RAAC has been identified but where there is no immediate cause for concern (Table 5) where the surveys have recommended periodical monitoring (annually or longer). We will put mechanisms in place to monitor these areas on an annual basis by suitably qualified personnel:

Site Name	Block Name	Monitoring
Lynebank Hospital	Tay View and Ward 12 Offices	Annual
Queen Margaret Hospital	Phase 1 Main Block	Annual
Adamson Hospital	Tarvit Ward	Annual
Glenrothes Hospital	Glenrothes Main Block	Annual

Table 4 - Areas for Annual monitoring

- Blocks where further investigation is required:

Site Name	Block Name	Further Investigation
Kirkcaldy Health Centre	Kirkcaldy Main Block	Yes
Lynebank Hospital	Psychology, Health Records and Health Storage	Yes
Lynebank Hospital	Main Building	Yes

Table 5 - Areas for further investigation

For the blocks where further investigation is required (Table 6), discussion is ongoing Nationally about how this can be done consistently across Scotland. While this is being carried out, risk assessments have been caried out in the three areas identified above by our Health and Safety Manager, which have resulted in several mitigating actions which have now been put in place.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

We have not yet identified areas where patient care is affected by RAAC and the areas where further investigation is required are not primarily patient facing.

2.3.2 Workforce

We are committed to providing staff with a continuously improving & safe working environment. We have taken a risk-based approach to minimising the risks to all staff.

2.3.3 Financial

In the short-term we have identified a contingency sum of £50k to support further investigations and provide any short-term mitigations. In the longer-term we will ensure that RAAC is included in the risk assessed backlog maintenance capital expenditure plan, where necessary. It is anticipated that those areas containing RAAC may have significant costs in the future if the RAAC becomes unstable or reaches the end of its life.

2.3.4 Risk Assessment / Management

The Asset Management System prioritises work based on the condition of the different blocks and systems within the estate. The system will be updated with RAAC information and will be used to prioritise backlog maintenance and capital expenditure going forwards.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

An Impact Assessment has not been carried out.

2.3.6 Climate Emergency & Sustainability Impact

There is no immediate impact on climate emergency and sustainability although there is a preference going forward to reuse existing buildings rather than replacement given the embodied carbon created during the construction period.

2.3.7 Communication, involvement, engagement and consultation

A post was published on Blink in September 2023 and following a discussion at Area Partnership Forum, an NHS Fife website has been developed Reinforced Autoclaved Aerated Concrete (RAAC) | NHS Fife to provide information in a transparent manner. It is likely that this resource will be updated with the information included in this paper as soon as reasonably possible.

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.

- Estates & Facilities Senior Management Team on 25 October 2023
- Executive Director Group on 2 November 2023
- Fife Capital Investment Group on 8 November 2023
- Fife Clinical Governance Committee on 12 January 2024
- Staff Governance Committee 11 January 2024
- Area Partnership Forum/Local Partnership Forum 24 January 2024
- Health & Safety Sub-Committee 8 March 2024
- Executive Director Group on 4 July 2024

2.4 Recommendation

This paper is provided to members a **"moderate"** level of assurance.

3 List of appendices

None.

Report Contact
Neil McCormick
Director of Property & Asset Management
Email neil.mccormick@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Briefing Paper: Alcohol and Drug Death Reviews in Fife**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Tanya Lonergan, Associate Director of Nursing** **Prof Susanna Galea-Singer, Clinical Lead, Addiction Services**

1. Situation

- **Ongoing Challenge:** The prevalence of drug and alcohol deaths remains a significant issue in Scotland, with Fife experiencing similar trends, although below the national average.
- **Review Demand:** High demand for alcohol and drug death reviews by Addiction Services persists, exacerbated by resource constraints leading to delays in the review process and concerns about the 'closing the loop' process.

2. Background

- **National and Local Prevalence:**
  - *Drug Deaths:* In Scotland, suspected drug deaths increased by 10% in 2023, with Fife also seeing an increase, including a recent cluster of young people's deaths. The rise is linked to potent synthetic drugs and changes in drug use patterns.
  - *Alcohol Deaths:* Alcohol-specific deaths in Scotland have steadily risen since 2012, with Fife following this trend but remaining below the national average.
- **Review Processes:**
  - *Addiction Services:* Conducts reviews for patients open to services at the time of death or within six months prior. Reviews include Alcohol & Drug Death Reviews involving the full Multi-disciplinary team. This review ensures timely quality improvement initiatives emerging from learning from death reviews to enhance the safety for patients, families and staff. The review templates, aligned to the MAT Standards are completed and reviewed by the Team Leaders, then sent in advance to the meeting panel members. The panel come prepared and discuss each case as a full multi-disciplinary team offering rich conversation and to support enquiry.
  - *Multi-Agency Drug Death Review Group (MDDRG):* This group reviews drug deaths across agencies, sharing findings to inform action plans

and service improvements. This includes the learning from the Addiction Service reviews to wider discuss.

  - *Mental health Services:* A successful pilot has been under taken within Mental Health Services. Using the same robust process and an adapted template, patient's deaths are reviewed at a joint meeting with members of the multi-disciplinary teams from both Mental Health Services and Addictions Services.

3. Assessment

  - There are currently **50** cases to be allocated for a Cluster review meeting (43 Addictions and 7 Mental Health).
  - Since July 2020, there have been 44 meetings held with **191** incidents involving a drug/alcohol related death "finally approved" and 43 are "being reviewed" in Datix (as at 19/08/24). There are currently 7 meetings scheduled for the remainder of 2024. 6 individual cases are discussed at each meeting. The service are currently reviewing team capacity and looking at ways to expedite remaining cases to be on track to review deaths in real time.

- **Action Plans & Process Improvements:**
  - Reviews are recorded in Datix, with learnings integrated into action plans, regularly reviewed in Addiction Services meetings.
  - The MDDRG Expert Delivery Group identifies shared themes from reviews to inform broader strategies.
- **Additional Challenges:**
  - *Resource Constraints:* The increasing drug deaths, changing drug trends, and the need to meet other service standards place a heavy demand on resources.
  - *Workforce and Financial Constraints:* Recruitment challenges, particularly for medical and administrative support, hinder the ability to manage the review process effectively. There is no financial capacity to add resources, exacerbating delays.

4. Risk Assessment

- **Key Risks:** The timeliness of reviews is at risk due to delays in report generation, lack of administrative support, staff availability, rising drug deaths, and changes in drug trends.

5. Recommendations

- To continue to support the Drug and Alcohol Death robust review process and take assurance on current position which is carefully monitored to ensure dedicated resource is available to meet demand.

NHS Fife

Meeting: **Clinical Governance Committee**

Meeting date: **6 September 2024**

Title: **Acute Services Redesign Programme Phase 1**

Responsible Executive: **Claire Dobson, Director of Acute Services**

Report Author: **Claire Dobson, Director of Acute Services**

Executive Summary:

- The Acute Services Redesign programme will contribute to NHS Fife's RTP Transform objective and underpin a range of service design and delivery work streams identified in the Reform, Transform and Perform Framework (RTP Framework).

- The initial three priority areas of the redesign programme are the formation of an Integrated Acute Respiratory Unit, the establishment of a Same Day Emergency Care (SDEC) model, and the redesign of surgical admission pathways.

- This work will be undertaken with immediate effect and Phase 1 will conclude by the end of March 2025.

- These 3 priorities are ultimately focused on improving patient experience by supporting delivery of care in the right place at the right time by the right clinician. A robust evidence base has underpinned the development of the phase 1 components to support the development of our system to uphold safe, effective, quality care delivery.

Purpose

This report is presented for:

- Assurance

This report relates to:

NHS Board Strategic Priorities

- To Improve Quality of Health and Wellbeing Services
- To Deliver Value & Sustainability

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper to provide assurance in relation to Phase 1 of the Acute Services Redesign Programme. The initial three priority areas of the redesign programme are the formation of an Integrated Acute Respiratory Unit, the establishment of a Same Day Emergency Care (SDEC) model, and the redesign of surgical admission pathways. This work will be undertaken from now with Phase 1 concluding by the end of March 2025.

2.2 Background

The Acute Services Redesign programme will contribute to NHS Fife's RTP Transform objective and underpin a range of service design and delivery work streams identified in the Reform, Transform and Perform Framework (RTP Framework). The overarching objective is to enable modern clinical models to develop to support safe, quality care delivery and facilitate clinical teams to operationalise the principles of Realistic Medicine.

NHS Fife faces a challenging and unsustainable financial and service delivery environment. The most significant factor impacting the delivery of acute services is increasing demand, driven by population changes, not least an aging population. Alongside this the financial settlement and workforce supply factors are exigent; concomitant improvement work continues to manage down workforce vacancy challenges through creative, evidence based, skill mix to optimise workforce capacity within available arrangements. However, the Division's assessment is that significant structural change within service delivery models is required to effectively balance increasing demand and workforce supply factors.

The RTP Framework outlines the need to transform to a sustainable financial position, delivered through further choices and further actions. There is a collective ambition to enhance patient outcomes by developing pathways to the right care in the right place by the right professional, to optimise the deployment of resources available and deliver the triple bottom line.

The overall vision for the reconfiguration programme is to optimise the deployment of available resources to enable clinical models to develop and deliver values-based health and care to:

- Optimise unscheduled care pathways
- Maximise ambulatory pathways
- Reduce the need to care for patients in surge beds
- Protect surgical activity
- Co-locate key services

The objectives for redesign were synthesised from the initial engagement work with the Acute Extended Senior Leadership Team to form the basis of the subsequent engagement and option development. These objectives are:

- Allowing the right care, in the right place and at the right time
- Sustainable use of resources and site footprint
- System development of pathways to optimise <48hr stays
- Capacity for people to return next day to hot clinics for urgent care, where overnight care is not required

- Capacity for scheduled ambulatory model, where bed-based care is not required
- Facilitating realistic medicine, ensuring care is focused on clinical and patient value
- Flow that removes any requirement for surge into DIU / SEAL / Surgical wards

Service redesign therefore requires the following components:

- Alignment / co-location of services to support integrated working
- Sufficient capacity for both medical and surgical assessment and admission pathways
- Optimisation of capacity for <48hr admission treatment pathways
- Robust medical and surgical assessment models and pathways
- Redesign of the medical front door with three key components:
    - Same Day Emergency Care (SDEC) unit, that includes ambulatory assessment,
    - 24/7 assessment beds
    - Scheduling of unscheduled care, with 'hot clinic' and remote support
- Establishment of an Integrated Acute Respiratory Unit (IARU)
- Clinical accommodation that is fit for purpose and flexible for continual service improvement
- Digital system and process developments to enable the transformation

The envisioning discussions agreed key principles which the programme needs to deliver:

- Enable safe, effective clinical care
- Co-design with teams
- Optimise co-location
- Reduce risk

2.3 Assessment

The programme receives an overall mandate from the RTP Executive Group and is the key transformation programme within Acute Division contributing to NHS Fife's Reform, Transform and Perform portfolio. The initial focus of this programme between now and the end of March 2025 will be on Acute Reconfiguration. The Acute Services Redesign Programme Board will oversee all elements of the programme.

The first three priority areas for the Acute Services Redesign have been identified as:

- Integrated Acute Respiratory Unit
- SDEC Model and associated redesign of the medical front door
- Redesign of Surgical Pathways

A short life working group (SLWG) has been established to co-ordinate and progress each priority project. This activity is being underpinned by a phasing a logistics group which is seeking to support co-ordination and wider communication, particularly with associated ancillary and corporate teams.

Integrated Acute Respiratory Unit

This project will see the co-location of respiratory wards and provide capacity for scheduled unscheduled care in ward 53 and 51. This will involve moving the ward team currently based in

ward 43 to ward 53. The pathway from the front door will be shortened and capacity created for hot clinic within a respiratory assessment room, with scheduled care reducing the requirement for emergency admissions. Pathway improvement work with the community based Respiratory Nurse Specialists is underway. This will see the respiratory bed base reduce by 6 beds (from 40>34)

OPAT will co-locate within the integrated respiratory unit. This will support medical cover and elongate the OPAT day.

The shape of the integrated unit is illustrated at figure 1.

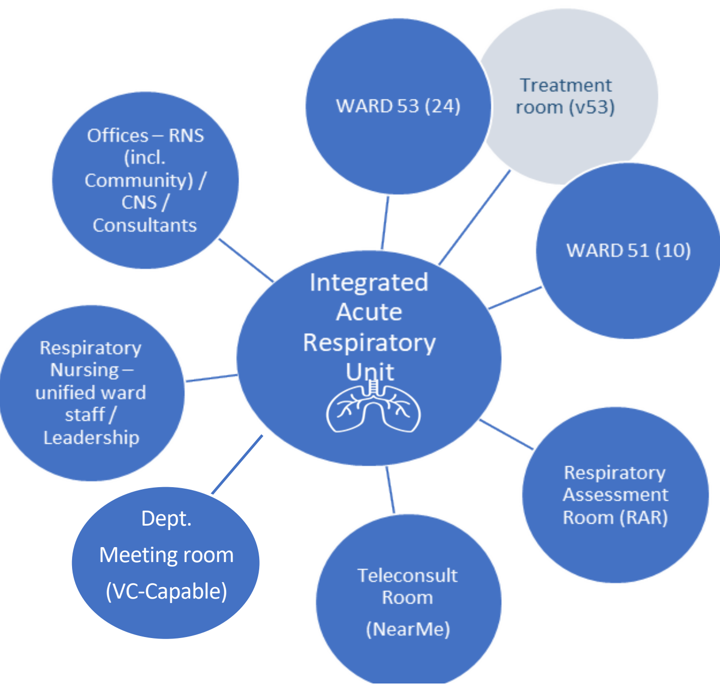


Figure 1

The ongoing role of ward 43 is being explored within the medical directorate as a 30 bedded short stay medical ward.

The anticipated benefits from this project will be more responsive care that helps people stay at home for longer, improved workforce efficiencies and capacity for service development (e.g. Non-invasive Ventilation).

The implementation timeline is summarised in figure 2:

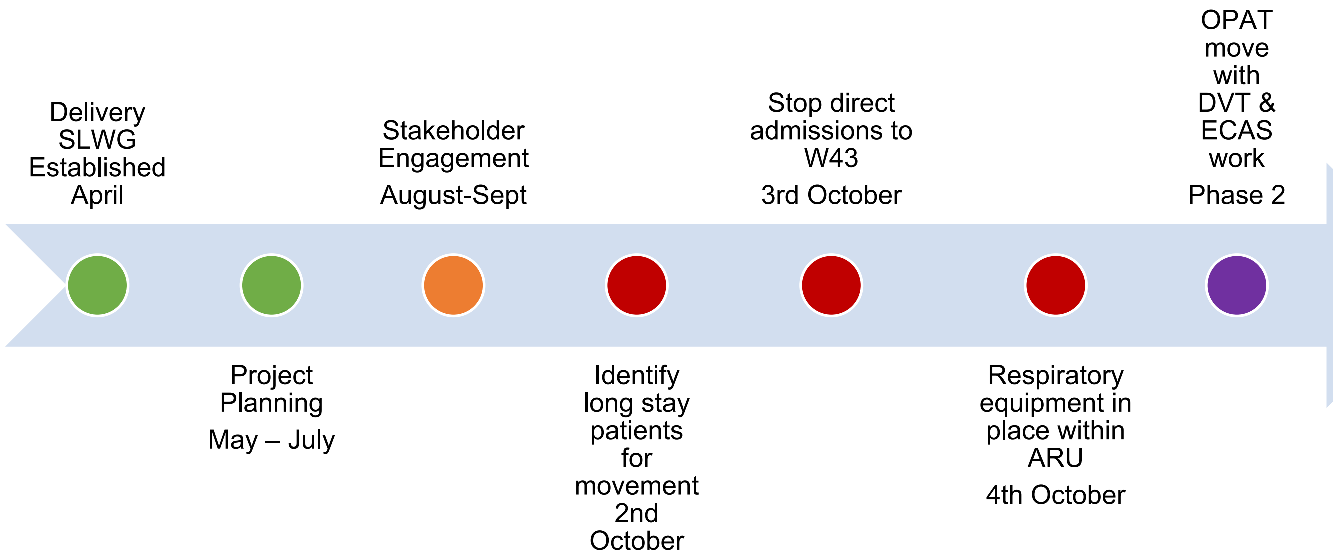


Figure 2

SDEC Model and associated redesign of the medical front door

The goal in redesigning the medical front door is to build on the learning from the creation of the Rapid Triage Unit and the development of Same Day Emergency Care Model (SDEC) models within other Boards.

The SDEC, incorporating RTU, ECAS and DVT services, will enable people who would otherwise be considered for an emergency admission to be rapidly assessed, diagnosed, treated and discharged home on the same day. For some this will see the scheduling of diagnostics and treatment, for the next day. The SDEC will extend the rapid triage and care approach (opening 09:00-22:00 Sunday-Friday, 0900-20:00 Saturday for ambulatory pathways (last patient received 2 hours before closing).

An integral part of the model development is the expansion of 24/7 assessment capacity for people for people requiring support for less than 48 hours.

Both these elements will sit within the current AU1 footprint.

To ensure that the required model of care delivery and associated length of stay within these areas can be sustained flow and pathways across the site and within the community will require to be revised. For example, scheduling of SDEC appointments at point of referral via FNC will augment the modest scheduling undertaken with RTU currently.

Specialities, diagnostic and ancillary teams will work with the SLWG to develop pathways to support the rapid response required for these models to achieve the anticipated 11% reduction in admissions of an SDEC model and a 55% front door discharge rate and the concomitant estimated reduction in LOS by 1 day by enabling rapid assessment and care within the <48 hour pathway.

An extensive workforce modelling exercise has been undertaken. This will require investment in:

- Medical Consultants
- Radiology
- AHP
- Portering
- ANP

A key enabler to this priority is the creation of a ringfenced short-stay medical ward, supported by the same wider acute medical team. Initial thinking is to test this element within the ward 43 footprint. SDEC and short stay medical ward proposed would mean the team would be able to in-reach to ED, as evidenced by the test of change, enabling circa 15 patients per day to be quickly transferred from ED to SDEC.

The anticipated benefits of this project are reduced length of stay and associated clinical risks/costs, evidence from NHS England is a minimum of 11% more people complete their care on the same day. Enhanced workforce efficiencies, and enhanced carer pathways in nursing and AHPs by expanding advanced practice opportunities through skill mix.

Redesign of Surgical Pathways

In 2023/24 AU2 experienced a 33.5% increase in GP admission and a 60% increase in admissions via ED compared with 2019/20. At the same time 80% of surgical admission breach the 4hour access standard. Working within the current workforce establishment the directorate will focus on pathways for assessment, diagnosis and treatment into and through ED and the admission unit and onto speciality wards and to optimise the potential to schedule unscheduled activity and enhance patient and staff experience.

Across these three priority projects

The combined impact of these projects is anticipated to be delivery for realistic medicine, reduction in length of stay and workforce sustainability.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

These 3 priorities are ultimately focused on improving patient experience by supporting delivery of care in the right place at the right time by the right clinician. A robust evidence base has underpinned the development of the phase 1 components to support the development of our system to uphold safe, effective, quality care delivery.

2.3.2 Workforce

The components of phase have been developed with teams and are focused on improving their experience, supporting recruitment and retention. The programme structure will ensure staff side and teams are represented in the ongoing refinement and implementation.

2.3.3 Financial

The focus of the Acute Services Redesign Programme is clinical quality and safety. It is anticipated that financial, cost avoidance benefits will be realised to contribute to the financial goals of the Transform objective.

In the development of this proposal several cash releasing or cost avoidance opportunities have been identified. Quantifying some impacts will require a retrospective analysis in terms of cash releasing or efficiency, however key indicators are identified in support of benefit realisation.

It is anticipated that capital and revenue resource will be required to fully implement re-imagined acute care models. The initial phase of the proposal focuses on co-location of services. Further phases will require investment. Business case proposals will be brought forwards.

2.3.4 Risk Assessment / Management

A programme risk log has been drafted and will be presented to the RTP executive team for assurance in the risk assessment cycle.

It is recognised that Phase 1 of the programme will be implemented over the winter period which will add to the challenge of re-imagining and redesigning services as teams cope with increased demand and work force challenges.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

The three elements of phase 1 are focused on supporting timely access to care for all Fife citizens on the basis of need. Metrics will be developed to measure the programmes impact which take cognisance of the Board's equalities duties.

2.3.6 Climate Emergency & Sustainability Impact

There is no anticipated impact to the aims and targets outlined by the NHS Scotland Climate Emergency and Sustainability strategy for NHS Fife because of the work outlined, other than some reduction in repeat testing which may support a reduction in consumables / waste.

2.3.7 Communication, involvement, engagement and consultation

The three projects within phase one are being progressed via short life working groups (SLWG) which have staff side and teams' representatives involved. Each group will support full communication and early engagement with teams impacted by the changes involved.

2.3.8 Route to the Meeting

- Acute Services Redesign Programme Board
- Acute Clinical Governance Committee - Integrated Respiratory Unit Report 24th July 2024
- RTP Executive Huddle 29th August 2024

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance in relation to Phase 1 of the Acute Service Redesign Programme.

3 List of appendices

None.

Report Contact

Claire Dobson
Director of Acute Services
claire.dobson3@nhs.scot

ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
20TH AUGUST 2024

1. Purpose

To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 20th August 2024. This assurance statement summarises the key aspects of business covered.

	Summary	Assurance Level
1.	**NHS Fife Duty of Candour Process and Procedural Guidance**	Moderate
	The Associate Director for Quality and Clinical Governance presented a proposed update to the Duty of Candour (DoC) process and procedural guidance to include: • Process for monitoring quality performance indicators to measure adherence with the legislation • A streamlined approach to the identification of cases for review by the Medical Director who determines if DoC is activated • Updated letter of apology to support a sincere and heartfelt apology that speaks to the person • Consistency of approach across NHS Fife The group welcomed the recommendations and were asked to reflect and feedback on the proposed changes. Finalised process and procedural guidance anticipated to be presented back to group in October 24 for endorsement.	
2.	**SBAR NHS Fife Health & Social Care Partnership Complaints Timescales**	Moderate
	The Nurse Director for the Health and Social Care Partnership (HSCP) presented an overview of the situation in HSCP in respect of response time to complaints. Staffing and training issues have contributed to the reduced performance in HSCP. The following actions are underway to improve the position: i. Close working with the Patient Experience Team- weekly meetings established with work required to ensure consistent attendance ii. Quality Improvement work focusing on an Escalation SOP and feedback questionnaires. A new investigation template is also being tested iii. Work to categorise complaint complexity has been completed iv. Refresh of training material v. Implementation of Single Point of Contact – enhancing communication The impact of delays in responding to complaints for patients and families	

	was recognised and the need to balance this with the quality of response provided. Also noted was the work required to support effective learning from complaint themes. Head of Patient Experience is working on an escalation process for complaints and will share with the group.	
3.	**NHS Fife Clinical Governance Oversight Group Terms of Reference**	Significant
	The Terms of Reference (ToR) for the group was reviewed. This included: • Updated membership to include: - General Managers from Acute Services and the Health and Social Care Partnership - Associate Medical Director for HSCP - Associate Director of Medical Education • Consideration of Digital and Information representation • Role and Remit enhanced focus on learning • Connections with Pharmacy governance structure also to be considered Finalised ToR to be brought to the group for endorsement in October 24.	
4.	**NHS Fife Integrated Performance Quality Report (IPQR)**	Moderate
	The IPQR was brought for assurance with discussion on the metrics and governance arrangements for agreeing of local targets v national targets. A paper outlining the local targets with a review of where these have been agreed will be brought back to the October 24 meeting. Work has also commenced to refresh the adverse events section of the IPQR.	
3.	**NHS Fife Health & Social Care Partnership Clinical Governance Assurance Report**	N/A
	There were no escalations to the group. It was noted that there was an increase in medication incidents. It is thought this might be related to increased reporting due to raised awareness following an incident earlier this year. This is being kept under review. The Chair noted the increased in ligature incidents from August 23-February 24. With the rate of restraint also increasing during this period. It was noted that that a report is expected in response to this at the Quality Matters Assurance Group, HSCP in August 24.	
4.	**NHS Fife Acute Services Division Clinical Governance Quality Assurance Report May 2024**	Moderate overall Limited in respect of escalation
	Escalation It was escalated to the group that that Public Health Scotland have requested to meet NHS Fife to review the Scottish Hip Fracture	

	Standards in Fife. In particular time to theatre for patients with a hip facture (QPI <36 hrs). It was noted at the June 24 meeting that NHS Fife has been an outlier for time to theatre for 5 years with updates requested back to the group. It was agreed that: • Work should continue with actions set out at the June 24 meeting • Further update to come back to the group in October 24 • Schedule update to Clinical Governance Committee in November 24 Other business noted by the group included: • Continued challenge with waiting times • Tissue Viability training developed with University of St Andrews and University of Dundee • Improvement work to reduce extravasation in radiology • Proposed changes to respiratory inpatient areas to establish a co-located respiratory unity	
5.	**NHS Fife Clinical Policy & Procedure Update**	Significant
	The group were given assurance that they have a 100% compliance rate for all clinical policies and procedures overseen by the NHS Fife Policy and Procedure Group.	
6.	**NHS Fife Activity Tracker**	N/A
	One new Consultation • Draft guideline consultation Asthma: diagnosis, monitoring and chronic asthma management issued 18 June 2024 New standard issued • Draft Pregnancy Screening Standards: Chromosomal and health conditions issued 9 July 2024	
7.	**Annual Review of Terms of Reference for NHS Fife Clinical Governance Oversight Group**	N/A
	Group requested to review terms of reference. Associate Director for Quality and Clinical Governance advised that there would be value in management attending the meeting and has approached the Director of Acute Services and Director for Health and Social Care Partnership	
8.	**NHS Fife Partnership Review of Children and Young People's Deaths Annual Report**	Moderate
	The second annual report of the work of the Child Death Oversight Panel was presented. Very sadly there has been 20 deaths of children and young people between January 23 and March 24. It was noted that due to the small numbers of deaths it was not possible to share detailed learning points and it was noted that the development of a multiagency learning event and the evolving action plan would be discussed at the Review of Children & Young Person Governance Meeting. Report scheduled to be presented at September Clinical Governance Committee.	
9	**SBAR NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as of August 2024**	Moderate

	Risks aligned to the Clinical Governance Committee (CGC) were presented. There was consensus that the Optimal Clinical Outcome Risk would be re-written and presented to the group in October 24. Cancer Waiting Times, Access and Whole System Capacity Risks to be added to the group's workplan as aligned to the revised CGC workplan.	
10.	**NHS Fife Controlled Drugs Accountable Officer Annual Report 2023-24**	Significant
	The group took significant assurance from this report which is scheduled for CGC in Sept 24.	
11.	**Adverse Events**	Moderate
	The group received an overview of the sub category of incident within the "other clinical" category. In 2023 18 of the 68 SAERs commissioned fell within this category. Assurance was provided that there was no non-random variation that would indicate a concern. The group welcomed work that will be progressed to redefine this category to give more visibility of the themes within this category.	
12.	**NHS Fife Adverse Event Staff Support Pathway**	Moderate
	The group unanimously supported the Adverse Event Staff Support Pathway. This work recognises the impact that being involved in an adverse event has on our staff and seeks to implement a structured support response by trained individuals. The group noted the importance of supporting staff and the positive cultural impact of this work. Further discussion required with Senior Leadership Teams to embed this work.	
13	**NHS Fife Deteriorating Patient Report Quarter 1 April- June 24**	Moderate
	The Clinical Lead for Deteriorating Patients presented the quarter 1 report which summarised. Key points included: • The mortality rate for actual cardiac arrest of which there were 16 was 38%. • There had been an improvement in structured response in VHK to 60%. • Workshop planned for 23rd August 24 to define improvement workplan for next 12 months The focus of this work and impact was recognised by the Chair and the group.	
14	**NHS Fife Deteriorating Patient Flash Report Cardiac Arrests January to June 2024**	Moderate
	The flash card has been developed to share outcomes of cardiac arrest reviews with staff and support learning. The flash report sets out areas of good practice and areas for improvement further to cardiac arrest reviews: Good practice noted following cardiac arrest reviews • Prompt/timely recognition of deterioration • Clear evidence of senior review • Observations completed on time • SR Sticker used correctly and hourly observations completed as appropriate • Clearly noted plan and ceiling of care documented in notes	

	Areas of improvement identified from cardiac arrest reviews • Use of Structured Response (SR) sticker when a patient has an Early Warning Score (EWS) of 3 or more • Admission document for escalation status has not been completed fully • Earlier decision regarding DNACPR • Better fluid balance chart documentation • Observations not obtained after 60 minutes when patient FEWS 4	
15	**Linked Committee Minutes**	
	Escalations made to the group were not able to be addressed in the meetings due to the full agenda, as such these will be responded to out with the meeting in advance of the October 24 meeting: NHS Fife point of Care Testing Committee • Challenges in identifying a new chair for the committee- now resolved and new chair identified NHS Fife Resuscitation Group • Resuscitation team vacancy • Replacement defibrillators – recommendation to align to National Defibrillator Procurement Framework due for completion in 2025 NHS Fife HSCP Inpatient Falls Group • Concerns regarding the use of lateral lifters and the numbers of staff required	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Corporate Risks Aligned to the Clinical Governance Committee, including update on Optimal Clinical Outcomes**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards**

Summary

This paper provides an update on the risks aligned to this Committee since the last report on 12 July 2024. The committee are asked to:

- take a moderate level of assurance from all the actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.
- note the recommendation from the Risks and Opportunities Group (ROG) and Clinical Governance Oversight Group (CGOG) to close the Optimal Clinical Outcomes risk and reframe a new risk and comment on the suggested wording of the new risk.
- note the recommendation made to CGC to move the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to an operational risk held by Acute Services and the Director of Property & Asset Management.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife
- NHS Fife Board Strategic Priorities
  - To Improve Health & Wellbeing
  - To Improve Quality of Health & Care Services
  - To Deliver Value and Sustainability

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

- Safe
- Effective

- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the risks aligned to this Committee since the last report on 12 July 2024.

The Committee is invited to:

- note the corporate risks as at 20 August 2024 at Appendix 1;
- review all information provided against the Assurance Principles at Appendix 2; and the Risk Matrix at Appendix 3;
- conclude and comment on the assurance derived from the report.
- note the recommendation from the Risks and Opportunities and Clinical Governance Oversight Group on the Optimal Clinical Outcome risk.

2.2 Background

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

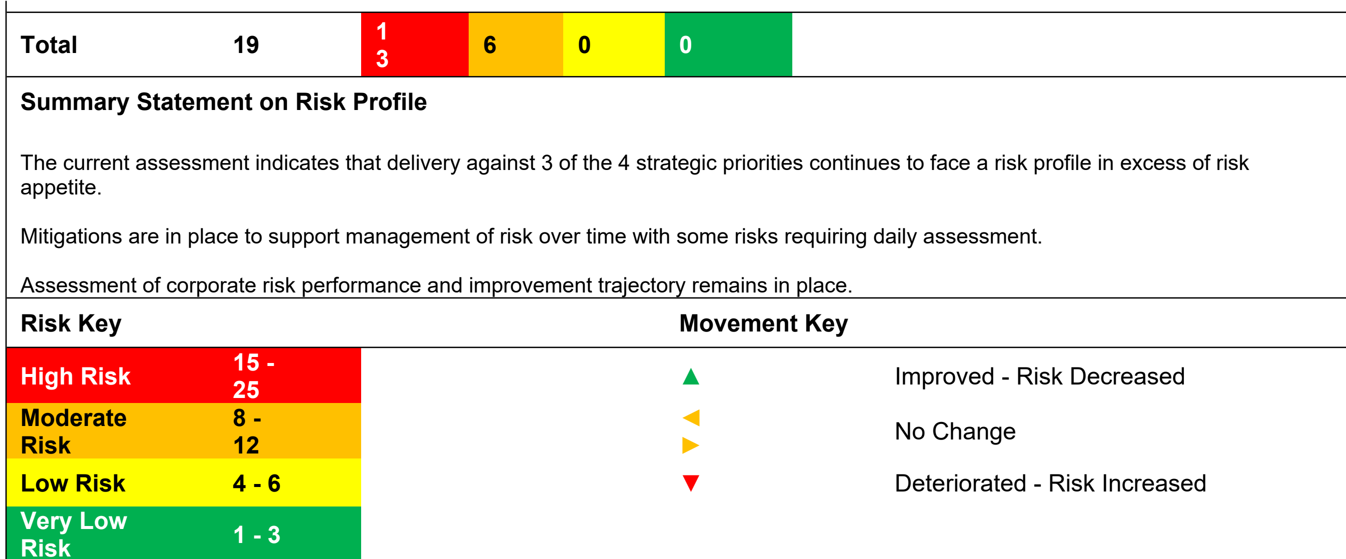
- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

The Strategic Risk Profile as at end of June is provided at Table 1 below.

Table 1: Strategic Risk Profile

Strategic Priority	**Total Risks**	**Current Strategic Risk Profile**				**Risk Movement**	**Risk Appetite**
To improve health and wellbeing	**4**	**2**	**2**	**-**	**-**	◄►	**High**
To improve the quality of health and care services	**6**	**4**	**2**	**-**	**-**	◄►	**Moderate**
To improve staff experience and wellbeing	**2**	**2**	**-**	**-**	**-**	◄►	**Moderate**
To deliver value and sustainability	**7**	**5**	**2**	**-**	**-**	◄►	**Moderate**



Total	19	13	6	0	0

Summary Statement on Risk Profile

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

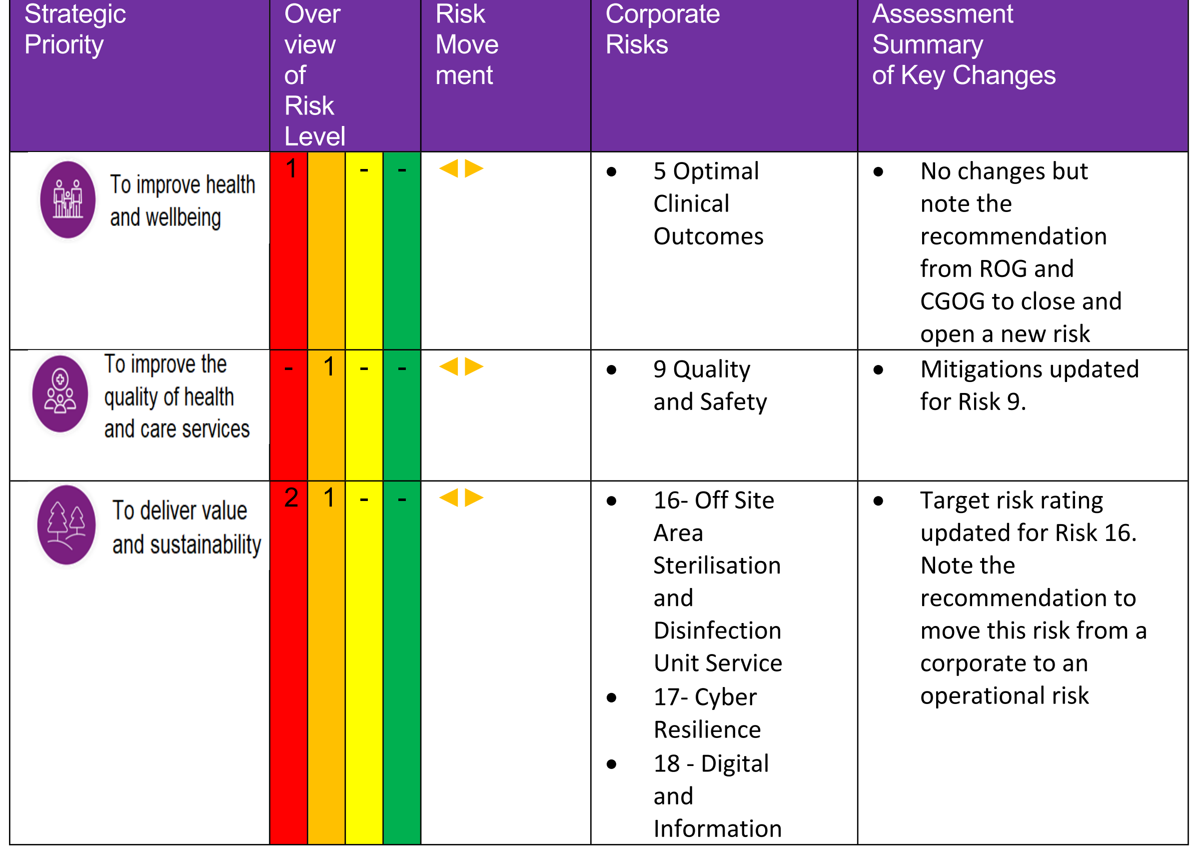
Mitigations are in place to support management of risk over time with some risks requiring daily assessment.

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

Risk Key		Movement Key	
High Risk	15 - 25	▲	Improved - Risk Decreased
Moderate Risk	8 - 12	◄►	No Change
Low Risk	4 - 6	▼	Deteriorated - Risk Increased
Very Low Risk	1 - 3		

Details of the risks aligned to the Clinical Governance Committee are summarised in Table 2 below and at Appendix No. 1.

Table 2: Risks Aligned to the Clinical Governance Committee



Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1		-	-	◄►	• 5 Optimal Clinical Outcomes	• No changes but note the recommendation from ROG and CGOG to close and open a new risk
To improve the quality of health and care services	-	1	-	-	◄►	• 9 Quality and Safety	• Mitigations updated for Risk 9.
To deliver value and sustainability	2	1	-	-	◄►	• 16- Off Site Area Sterilisation and Disinfection Unit Service • 17- Cyber Resilience • 18 - Digital and Information	• Target risk rating updated for Risk 16. Note the recommendation to move this risk from a corporate to an operational risk

Members are asked to note that since the last report to the Committee:

- Five risks are still aligned to the Committee.
- The risk level breakdown remains - 3 High and 2 Moderate

- Note the recommendation from ROG and CGOG to close the Optimal Clinical Outcomes risk and reframe a new risk.

Details of all risks are contained within Appendix 1.

Risk Updates

Risk 5 - Optimal Clinical Outcomes
Following consideration of the updated Deep Dive review at the Committee's meeting on 1 March 2024, there was further discussion through the Risks and Opportunities Group (ROG) on whether it is appropriate to close the risk and develop a revised risk or risks. Following this and further discussion at Clinical Governance Oversight Group (CGOG), the recommendation was made to EDG on the 5th September 2024 to close the risk and reframe as suggested.

There is a risk that delivery of care that results in the best measurable changes in health and quality of life for patients will be impacted by a mismatch between demand and available capacity resulting in increased unscheduled care, diagnostic and outpatient waiting times.

Risk 9 - Quality and Safety
The Associate Director of Quality and Clinical Governance advises that one of the root causes of this risk is that there is a requirement to further develop the approach to organisational learning. A paper setting out a proposed approach to refreshing the work of the Organisational Learning Group was shared with the Clinical Governance Oversight Group in April 2024 with a formal update scheduled to the Executive Directors in August 2024. The approach is also being shared at the Board development session in August 2024.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service
Recommendation made to CGC (and on to the NHS Fife Board as appropriate), to move the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to an operational risk held by Acute Services and the Director of Property & Asset Management.

Details are provided in Appendix No. 1.

Next Steps
The Corporate Risk Register will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations. It is recognised that consideration will be required in terms of reviewing the existing corporate risks and any new risks aligned to the CGC, in the context of the current operating landscape including the financial pressures faced and the developing Reform, Transform, Perform Programme. This will also apply to the Corporate Risk Register as a whole.

The Board's Risk appetite is currently under review. The ROG will seek to enhance its contribution to the identification and assessment of emergent risks and opportunities and make appropriate recommendations on the potential impact upon the Board's Risk Appetite position. The Group will also contribute to the development of the process and content of Deep Dive Reviews as part of a broader consideration of the Board's assurance framework.

The Access to Outpatient, Diagnostic and Treatment Services, Cancer Waiting Times and Whole System Capacity risks have now been scheduled to come to CGC once per year secondary to the update to Finance, Performance & Resource (FP&R) Committee for consideration of the impact on quality of care.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities. It is expected that the application of realistic medicine principles will ensure a more co-ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

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

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Management and oversight of the corporate risks aligned to this Committee continue to be maintained, including through close monitoring of agenda, work- plans, and clear governance through appropriate groups and committees. The latter allow for due diligence to occur, contributing to more transparent decision making and good corporate governance.

Risk Appetite

Members are asked to note the improving risk profile, with 60 % (3) of the risks now within risk appetite for their respective domain.40% (2) of the risks remain above risk appetite.

Risk 5 aligns to *Strategic Priority 1: 'To improve health and wellbeing'.*
The Board has a High appetite for risks in this domain.

- The risk has a current high-risk level and is therefore within appetite.

Risk 9 aligns to *Strategic Priority 2: 'To improve the quality of health and care services'.*
The Board has a Moderate appetite for risks in this domain.

- The risk has a current moderate risk level and is therefore within appetite.

Risks 16, 17 and 18 align to *Strategic Priority 4: 'To Deliver Value and Sustainability'.*
The Board has a Moderate appetite for risks in this domain.

- Risk 16 has a current moderate risk level and is therefore within appetite.
- Risks 17 and 18 have a current high-risk level and are therefore above risk appetite.

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement with stakeholders.

2.3.8 Route to the Meeting

- Gemma Couser, Associate Director of Quality & Clinical Governance on 22 August 2024
- Alistair Graham, Associate Director of Digital & Information on 22 August 2024
- Neil McCormick, Director of Property & Asset Management on 22 August 2024
- Dr Chris McKenna, Medical Director, on 22 August 2024
- Dr Joy Tomlinson, Director of Public Health on 22 August 2024

2.4 Recommendation

This paper is provided to members for **discussion** and to provide a **“moderate”** level of assurance that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.

3 List of appendices

- Appendix 1 - NHS Fife Corporate Risks aligned to the CGC as at end of August 2024
- Appendix 2 - Assurance Principles
- Appendix 3 - Risk Matrix

Report Contact
Dr Shirley-Anne Savage
Associate Director for Risk & Professional Standards
Email shirley-anne.savage@nhs.scot

Appendix 1

NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as 20 August 2024

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (High)	Risk Owner
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	Recommendation from the Risks and Opportunities Group (ROG) and Clinical Governance Oversight Group CGOG) is to close the Optimal Clinical Outcomes risk and reframe a new risk. The Board has agreed a suite of local improvement programmes, as detailed in the diagram below and related activities, to frame and plan our approach to meeting the challenges associated with this risk.	High 15 (L5xC3)	Mod 10 (L5xC2) by 30/09/24	◄►	Within	Medical Director

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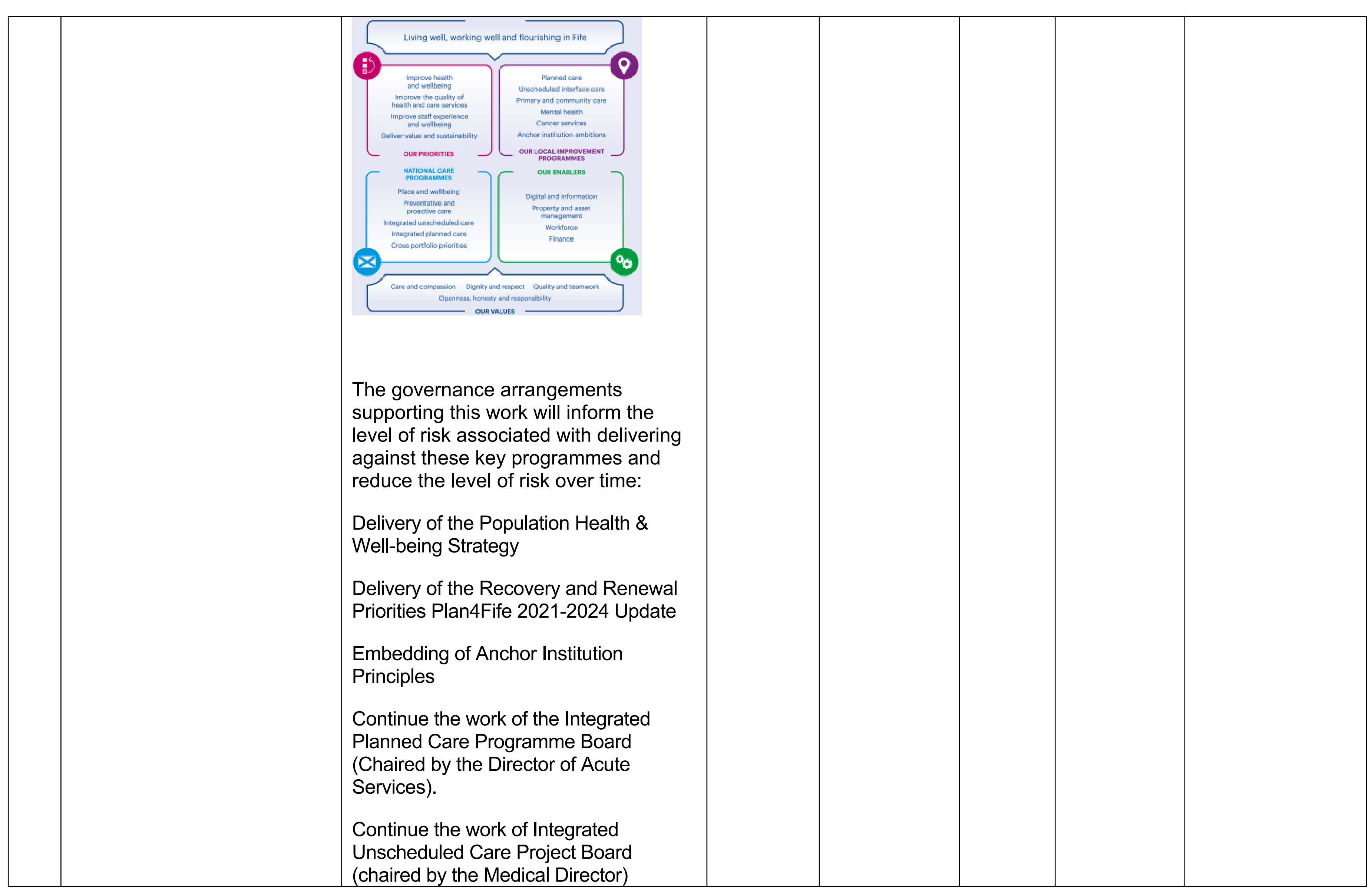

The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time:

Delivery of the Population Health & Well-being Strategy

Delivery of the Recovery and Renewal Priorities Plan4Fife 2021-2024 Update

Embedding of Anchor Institution Principles

Continue the work of the Integrated Planned Care Programme Board (Chaired by the Director of Acute Services).

Continue the work of Integrated Unscheduled Care Project Board (chaired by the Medical Director)
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		reporting to the Clinical Governance Committee three times per year. Continue the work of the Acute Cancer Services Delivery Group (chaired by the Director of Acute Services) reporting to the Cancer Governance and Strategy Group (chaired by the Medical Director). Continue to develop and implement Annual Delivery Plans for the Cancer Framework. Continue the work of the Primary Care Strategy Group Continue work on the Mental Health Redesign Programme Continue the work of the Scheduled Care Group Review the Scottish Government (SG) Value Based Health & Care. A Vision for Scotland, December 2022 document against our local plans. Continue escalation of issues through Senior Leadership Teams to Executive Director's Group then through to Clinical Governance Committee and other committees as appropriate Implement the Fife H&SCP Strategic Plan for Fife 2023-26 Implement the Cancer Framework Delivery Plan 2024/25 Ensure the NHS Fife Realistic					

		Medicine/Value Based Health Care Delivery Plan aligns with the Scottish Government (SG) Value Based Health & Care. Action Plan 2023.					

To improve the quality of health and care services

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by Date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
9	**Quality & Safety** There is a risk that if our governance arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the Clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. One of the root causes of this risk is that there are “no effective system of supporting effective organisational learning”. A paper setting out a proposed approach to refreshing the work of the Organisational Learning Group has been shared with the Clinical Governance Oversight Group	Moderate 12 (L4 x C3)	Low 6 (L3 x C2) by 31/03/25	◄►	Within	Medical Director

		in April 24 with a formal update scheduled to the Executive Directors in August 24. The approach is also being shared at the Board Development Session in August 24. The paper includes a workplan for 2024/2025 and outlines a number of activities the group will progress. The Organisation Learning Group meetings have now been reestablished to continue this work.					

To deliver value and sustainability

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
16	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. The National Decontamination Collaborative Programme Board is Chaired by the Director of Property & Asset Management (NHS Fife) and is developing a Initial agreement for submission to SG recognising that this is a National Problem. To recommend to the NHS Fife Board, to move the ‘Off-Site Area Sterilisation and Disinfection Unit Service’ risk from the Corporate Risk Register to an	Mod 12 (L4xC3)	Low 6 (L2xC3) by 01/04/2026 at next SG funding review	◄►	Within	Director of Property & Asset Management

		operational risk held by Acute Services and the Director of Property & Asset Management Establishment of local SSD for robotics is progressing with an indicative date of 31/12/23. Health Facilities Scotland (HFS) has agreed the design and the unit at St Andrews Community Hospital (SACH); the timescale to become operational has been revised from December 2023 to possibly June 2024. Work is underway to meet this target. An option appraisal for delivery of the service is being explored. Ensure that mitigations are in place to ensure that no trays are damaged while they are handled and stored in NHS Fife to include new racking and training. Staff have received training in the safe handling of trays. Training is being repeated on a yearly basis. Staff must inspect each tray prior to loading on to storage system. New racking system installed early March 2022 costing £27,000 and prevents the stacking of trays. Tins purchased in early 2022 costing £29,000 in use to protect our heavy trauma and orthopaedic trays A trial of foam corners has been					

		instigated by Tayside. Ensure that contingency stock has been procured to mitigate the effects of any down-time on the service to include: - •At least 3 Days of Trauma trays •At least 3 days of obstetric trays Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays. Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely manner. Regular Liaison meetings to discuss issues with the service have been taking place since 2021. Discussions are taking place about changing some of the terms in the SLA to allow defective trays to be identified at point of use rather than at point of delivery (July 2023). Consideration of alternative providers to determine whether value for money is being provided and whether increased resilience can be provided continues. Involvement and influencing the National group looking at capacity and resilience in CDU provision across Scotland. This group, facilitated by					

		National Services Scotland (NSS) will make recommendations to the Scottish Government (SG) about how best to increase capacity and resilience within NHS Scotland. This Group was convened in 2021. The Decontamination Collaborative Programme Board (DCPB) is now chaired by the Director of Property & Asset Management and has been briefing SG through regular meetings. Work with Regional partners to identify synergies in service delivery including the developing business plan for re-provision of CDU capacity within NHS Lothian. Raise the profile of this issue at National Estates and Facilities Fora including National Strategic Facilities Group which includes key representatives from NSS and SG.					
17	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the previous year. The action plan for improvement has been presented to the Information Governance and Security Steering Group. The Deep Dive review for this risk was presented to Clinical Governance	High 16 (L4xC4)	Mod12 (L4xC3) by Sept 2024	◄►	Above	Medical Director

		Committee in January 2024. Management actions detailed continue to be progressed.					
18	**Digital & Information (D&I)** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the current digital programmes against current strategic objectives is complete and has governed by the Digital and Information Board. The annual delivery plan for 2024/25 will demonstrate a reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue). The revised strategy will include, financial and workforce planning, to support the mitigation of this risk. D&I Board have established new prioritisation and authorisation processes with ongoing review. ongoing review.	High 15 (L3xC5)	Mod 12 (L2xC4) by April 2025	◀▶	Above	Medical Director

Risk Movement Key
▲ Improved - Risk Decreased
◀▶ No Change
▼ Deteriorated - Risk Increased

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

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

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or Escalation / Recording

- Scrutiny or risk delegated to Committee

Year End Report

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

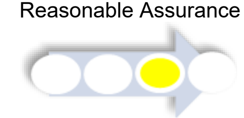
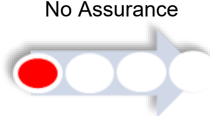
General Questions:

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

Specific Questions when analysing a risk delegated to the committee in detail:

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

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service, 2022

Risk Assessment Matrix

A risk is assessed as **Likelihood x Consequence**

Likelihood is assessed as Remote, Unlikely, Possible, Likely or Almost Certain

Figure 1 Likelihood Definitions

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances (5-10 years)	Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)	May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)	Strong possibility that this could occur – likely to occur (quarterly)	This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)

Consequence is assessed as, Negligible, Minor, Moderate, Major or Extreme.

Risk Level is determined using the 5 x 5 matrix below based on the AUS/NZ Standard. The risk levels are:

- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

Figure 2 Risk Matrix

Likelihood	**Consequence**				
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Extreme 5**
Almost certain 5	LR **5**	MR **10**	HR **15**	HR **20**	HR **25**
Likely 4	LR **4**	MR **8**	MR **12**	HR **16**	HR **20**
Possible 3	VLR **3**	LR **6**	MR **9**	MR **12**	HR **15**
Unlikely 2	VLR **2**	LR **4**	LR **6**	MR **8**	MR **10**
Remote 1	VLR **1**	VLR **2**	VLR **3**	LR **4**	LR **5**

Risks once identified, must be categorised against the following consequence definitions

Figure 3 Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable.**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk.	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope / quality / schedule.	Minor reduction in scope / quality / schedule.	Reduction in scope or quality, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim/. Complex justified complaint
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day. Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training / implementation of training.	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<10k)	Minor organisational / personal financial loss (£10k-100k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£250 k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry, FAI

Based on NHS Quality Improvement Scotland (February 2008) sourced AS/NZS 4360:2004: Making it Work: (2004) and Healthcare Improvement Scotland, Learning from Adverse Events: A national framework (4th Edition) (December 2019)

CLINICAL GOVERNANCE COMMITTEE

DATES FOR FUTURE MEETINGS

Date
2 May 2025
11 July 2025
12 September 2025
7 November 2025
9 January 2026
6 March 2026

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **10am**

A pre-meeting of Non-Executive Members is routinely held, beginning at **9.15am**

* * * * *

CLINICAL GOVERNANCE COMMITTEE
DELIVERY OF ANNUAL WORKPLAN 2024 / 2025

Governance - General							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Governance Matters							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee, Resilience Forum, Medical Devices)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
CGOG Assurance Summary Report	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Associate Director for Risk and Professional Standards**	✓	✓	✓ **Including update on Clinical Optimal Outcomes**	✓ **Cancer Waiting Times**	✓ **Access to outpatient, diagnostic and treatment services**	✓ **Whole System Capacity**
Review of Terms of Reference	**Board Secretary**						✓ Approval

Governance Matters (cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Strategy / Planning							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Annual Delivery Plan 2024/25 Scottish Government Response *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓	✓				
Annual Delivery Plan Quarterly Reports	**Director of Finance & Strategy / Associate Director of Planning & Performance**		✓ **Q4/2024**	✓ **Q1/2024**	✓ **Q2/2024**		✓ **Q3/2024**
Cancer Strategic Framework & Delivery Plan	**Medical Director/Associate Director for Risk and Professional Standards**				✓		
Clinical Governance & Strategic Framework Delivery Plan 2024/25	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to next mtg**	✓				
Value Based Health and Care Delivery Plan	**Medical Director**						✓
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
Quality / Performance							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
IRMER Inspection Report 2024	**Medical Director**		✓				

Quality / Performance (Cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**Removed from workplan, as a review of the framework will form part of a leadership review that will be undertaken.**					
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	**Deferred - due to timings**			✓		
Digital / Information							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Digital and Information Strategy 2019-24 Update	**Medical Director / Director of Digital & Information**		**Deferred to next mtg**	✓	✓		
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			
Information Governance and Security Steering Group Update	**Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						✓ **2025 report**
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Scottish Public Service Ombudsman Investigation Report	**Director of Nursing**	✓					
Patient Story	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Professional Standards							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Allied Health Professional Assurance Framework	**Director of Nursing**			✓ **Update**			
Advanced Practitioners Review Update	**Director of Nursing**			✓			

Annual Reports / Other Reports							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Adult Support & Protection Annual Report 2023/25 *(also goes to PHWC)*	**Director of Nursing**	**Deferred to May 2025**					
Care Opinion Annual Report 2023/24	**Director of Nursing**			✓			
Clinical Advisory Panel Annual Report 2023/24	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report 2023/24	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2024 *(also goes to PHWC)*	**Director of Public Health**			**Deferred to next mtg**	✓		
Fife Child Protection Annual Report 2023/24 *(also goes to PHWC)*	**Director of Nursing**		✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report 2023/24	**Medical Director**				✓		
Medical Appraisal and Revalidation Annual Report 2023/24	**Medical Director/Associate Director for Risk and Professional Standards**				✓		
Medical Education Annual Report	**Medical Director**				✓		
Medical Safety Review and Improvement Report 2023/24	**Director of Pharmacy & Medicines**				✓		
Occupational Health Annual Report 2023/24	**Director of Workforce**			**Deferred**		✓	
Organisational Duty of Candour Annual Report 2023/24	**Medical Director**					✓	
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation 2023/24	**Director of Nursing**					✓	
Prevention & Control of Infection Annual Report 2023/24	**Director of Nursing**				✓		
Radiation Protection Annual Report 2023/24	**Medical Director**	**Deferred to next mtg**	✓				

Annual Reports / Other Reports (cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Research & Development Progress Report & Strategy Review 2023/24	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report 2023/24	**Medical Director**					✓	
Review of Deaths of Children & Young People 2023/24	**Director of Nursing**			✓			

Linked Committee Minutes							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Area Clinical Forum	**Chair of Forum**	04/04	~~06/06~~ - **cancelled**	01/08	03/10	05/12	06/02
Area Medical Committee	**Medical Director**	13/02	09/04	11/06	13/08	08/10	10/12
Area Radiation Protection Committee	**Medical Director**	-	-	09/05	TBC		
Cancer Governance & Strategy Group	**Medical Director**		21/03 & 30/05	-	15/08	-	31/10
Clinical Governance Oversight Group	**Medical Director**	16/04	18/06	20/08	-	22/10	10/12
Digital & Information Board	**Medical Director**	-	09/05	-	23/07	15/10	-
Fife Area Drugs & Therapeutic Committee	**Medical Director**	17/04	-	19/06	21/08	23/10	18/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**		08/03 & 10/05	05/07	04/09	08/11	10/01
Health & Safety Subcommittee	**Chair of Subcommittee**	08/03	07/06	-	06/09	06/12	-
Infection Control Committee	**Director of Nursing**	07/02 & 03/04	05/06	07/08	02/10	04/12	-
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**	Ad-hoc					
Information Governance & Security Steering Group	**Director of Finance & Strategy**	~~16/04~~ – **deferred (date tbc)**	-	-	17/07	21/10	29/01
Medical Devices Group	**Medical Director**	~~13/03~~ - **cancelled**		12/06	11/09	11/12	-
Medical & Dental Professional Standards Oversight Group *(New group as from June 2024)*	**Medical Director**	-	11/06	09/07	14/10	-	07/01

Linked Committee Minutes (cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Research, Innovation & Knowledge Oversight Group	**Medical Director**	-	14/05	-	-	14/11	-
Resilience Forum	**Director of Public Health**		13/03	13/06	11/09	12/12	-
Ad-hoc Items							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Neonatal Mortality Review Response	**Medical Director**		✓				
Medical Devices Update	**Associate Director of Quality & Clinical Governance**		**Deferred to next mtg**	✓			
Re-form, Transform, Perform Programme Update	**Director of Re-form & Transformation**	✓					
Organisational Learning Update	**Associate Director of Quality & Clinical Governance**		**Deferred to next mtg**	✓			
IR(ME)R Inspection – Victoria Hospital, Kirkcaldy – 16-17 January 2024 - Final report	**Medical Director**		✓				
Deteriorating Patients Improvement Programme	**Medical Director**			✓			
The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Annual Report	**Director of Nursing**			✓			
Letter from the Scottish Government: Reforming Services and Reforming the Way We Work	**Chief Executive**		✓				
Transport of Medicines Audit Report	**Acting Director of Pharmacy**		✓ **For noting**				
Medicines Assurance Audit Programme Short Life Working Group Audit Report	**Acting Director of Pharmacy**		✓ **For noting**				
National Resilience Standards, Implementation in Fife	**Director of Public Health**	**Removed from workplan – National Standards are being reviewed within the Scottish Government**					
Health Emergency Preparedness, Resilience & Response (EPRR) Training & Exercise plan for 2024/25	**Medical Director**				✓ TBC		

Ad-hoc Items (cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Briefing on the NHS Dumfries and Galloway Cyber Incident	**Medical Director**				✓ TBC		
Rapid Cancer Diagnostics Services	**Medical Director**				✓ TBC		
Professional Standards Group Update *(also goes to SGC)*	**Director of Workforce**				✓		
Neonatal Mortality Review Health Improvement Scotland Report	**Medical Director**			✓			
St Andrews Community Hospital Security Breach Update & Action Plan	**Director of Finance & Strategy**			✓			

Matters Arising							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Health & Social Care Partnership Response to Community Associated E. Coli Bacteraemia and Clostridium Difficile Infection	**Director of Nursing**	✓					
Adverse Event Process for Drug Related Deaths	**Medical Director**		✓				
Reinforced Autoclaved Aerated Concrete Update	**Director of Property & Asset Management**			✓			
Briefing Paper: Alcohol and Drug Death Reviews in Fife	**Medical Director**			✓			
Reform, Transform, Perform - Acute Redesign Priorities	**Director of Acute Services**			✓			
Reform, Transform, Perform - Transforming Urgent Care	**Director of Acute Services**			✓ Private Session			

Development Sessions						
	Lead					
Principles of Clinical Governance	**Medical Director**	**07/05/24**				

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Annual Delivery Plan 2024/25** **Scottish Government Response and Quarter 1 Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

Executive Summary

- This report contains the service response to feedback received from Scottish Government in relation to Annual Delivery Plan (ADP) for 2024/25 as well as a Q1 update on progress.
- Services feedback provided further detail as part of ADP 2024/25.
- Some restrictions on Scottish Government funding has meant that a number deliverables cannot be delivered this year. The ADP submission indicates where this is the case.
- As of end of Jun-24 (quarter 1 of 2024/25), there are 4 deliverables that are **'complete'**, all of which were carried over from 2023/24. The majority of deliverables (75.8%/147) are **'on track'** with 8 deliverables that are **'unlikely to complete on time/meet target'**, two of which relate to this committee.

This report provides Moderate Level of Assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan 2024/25

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

- Safe
- Effective
- Person Centred

This report aligns to the following strand/s of the NHS Scotland Staff Governance Standard:

- Well informed
- Appropriately trained & developed
- Involved in decisions
- Treated fairly & consistently, with dignity & respect, in an environment where diversity is valued
- Provided with a continuously improving & safe working environment, promoting the health& wellbeing of staff, patients and the wider community

2 Report summary

2.1 Situation

This report contains the service response to feedback received from Scottish Government in relation to Annual Delivery Plan (ADP) for 2024/25 as well as a Q1 update on progress.

2.2 Background

The guidance for Annual Delivery Plan (ADP) 2024/25 was distributed to territorial NHS Boards on 4 December 2023. The planning priorities set out in the guidance are intended to give clarity on the high-level priorities which Boards should deliver in 2024/25, whilst remaining flexible enough to allow Boards to appropriately plan and prioritise within their own financial context.

The Annual Delivery Plan 2024/25 was submitted on 21 March 2024. The feedback letter from the Scottish Government was received on 28 May 2024 approving the plan stating that the Scottish Government was satisfied that the ADP broadly meets the requirements and provides appropriate assurance under the current circumstances.

2.3 Assessment

Fife Response to Scottish Government Feedback

Services were asked to provide a response to the feedback provided. This is summarised below.

SG Feedback	Fife Response
Primary and Community Care	
Confirmation that funding for Mental Health and Wellbeing in Primary Care and Community Settings has been paused with all further activities being delivered within existing resources.	Confirmed by Fife HSCP, who have highlighted that the initial project objective of MDT Primary Care teams is not deliverable due to pause in funding.
Continued deployment of OpenEyes	Fife HSCP have stated commitment to this but require to review model and revise planning due to funding position. This is a key deliverable within the Primary Care Strategy implementation plan.

Urgent and Unscheduled Care	
Further information on plans to deliver a 24-hour approach to Urgent Care, including HSCP-led MIUs and Urgent Care Centres.	Fife are currently reviewing the model for MIUs jointly between Acute and HSCP services. Following consultation and engagement and an options appraisal, recommendations will be presented via Committees for both the IJB and NHS Fife by Q3 of 2024/25.
Improve the delivery of Mental Health support and services	
Scottish Government acknowledged that high demand and recruitment challenges would impact on meeting RTT targets.	Fife HSCP welcomed ongoing engagement with national team.
Recovering and improving the delivery of Planned Care	
Scottish Government stated they will work with Boards relating to actions within Planned Care Plan, acknowledging significant financial pressures may have an impact on performance.	Revised Planned Care Plan submitted in Jul-24. Waiting times are monitored weekly with a focus on long waits.
Cancer	
Plan references Optimal Cancer Diagnostic Pathways for Lung and Head & Neck which will be reviewed in 2024/25 with any improvements being cost neutral.	Bids for the optimal pathways have been put forward through the DCE funding source. Optimising Lung and Head & Neck cancer pathways requires ongoing capacity from Radiology for timely acquisition and improved turnaround times for reports. There will be revenue costs associated with this service improvement.
The plan states that RCDS is at risk if no additional funding is secured.	Funding has been extended until end of Mar-25 and the service will continue with no anticipated risk.
The radiology strategic plan is unfunded so at risk it will not deliver the additional imaging capacity required to support cancer pathways.	There is no identified funding source for this capital or revenue investment.
Additional references to CMPs would be helpful.	Regional working ongoing in respect of implementation of the CMPs.
Health Inequalities	
References to the general ADP Strategic Plan and actions are extensive but it would be helpful to have more focus on the specific areas that the Board leads on.	Addiction Services have developed an innovative approach for the treatment and recovery of people physically and psychologically dependent on illicit benzodiazepines, as well as operational development of Rapid Access Clinics, as part of the commitment to same day prescribing and retention in services. Psychology and Therapy Services are leading a workforce development plan across all commissioned and statutory services of the Fife Alcohol and Drugs Partnership.
Child and Maternal Health	

Plan expresses some concerns around delivery of continuity of carer, and it would be helpful to include more detail on this. On the Women's Health Plan, the Board have identified a lead and a series of local priorities, though there are some concerns about whether these will be delivered upon due to financial challenges	The projection for the successful implementation of continuity of carer is now more positive and is predicted to be achieved within timeframe. This is due to the extension of the implementation date of Women's Health Plan to Jun-26 and successful staff recruitment to vacant posts.
Implementation of the Workforce Strategy	
Board should continue to work with the Scottish Government to drive closer alignment between workforce and delivery planning.	NHS Fife is continuing to implement the Board Workforce Plan for 2022-2025, in close collaboration with Planning & Performance, Finance and HSCP Workforce colleagues, pending receipt of the revised national workforce planning guidance.
Digital and Innovation	
Future plans should set out how NHS Fife will implement NHS Scotland Scan for Safety Programme by Mar-26	Details will be provided at the end of 2024/25 Q2.
Climate Emergency and Environment	
No Circular Economy detail is provided, and it would be useful to include information on this.	NHS Fife launched the 'warp-it' system in March 2024. Warp-it is a web service and re-use platform, for redistributing surplus furniture and equipment. Since its launch, it has over 450 members and has delivered over £39k in savings.
The Board will need to ensure that they have a plan for Entonox mitigation. A clear program needs to be articulated	A multi-disciplinary Entonox mitigation SLWG in place, led by the chair of the local medical gas committee.

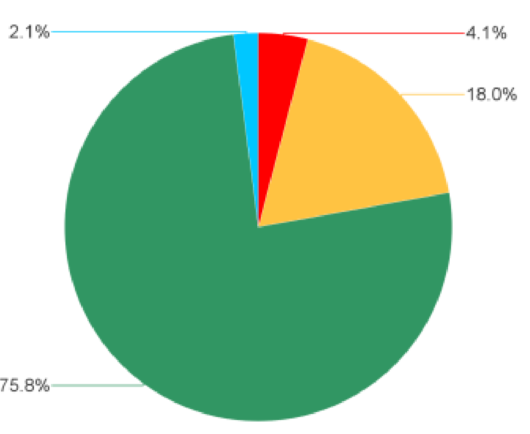
2024/25 Quarter 1 Update

There are 194 deliverables incorporated in ADP for 2024/25 across both NHS Fife and Fife HSCP. There are a number of deliverables carried over from 2023/24 as well as those relating to the implementation of the RTP. Additionally, there are 35 deliverables that are not aligned to a Recovery Driver.

Recovery Driver	n=159
1. Primary and Community Care	23
2. Urgent and Unscheduled Care	15
3. Mental Health	18
4. Planned Care	9
5. Cancer Care	6
6. Health Inequalities	28
7. Women & Children Health	13
8. Workforce	16
9. Digital & Innovation	19
10. Climate	12

Recovery Driver	n=194
All	2
To Deliver Value & Sustainability	58
To Improve Health and Wellbeing	36
To Improve Staff Experience and Wellbeing	20
To Improve the Quality of Health and Care Services	78

As of end of Jun-24 (quarter 1 of 2024/25), there are 4 deliverables that are **'complete'**, all of which were carried over from 2023/24. The majority of deliverables (75.8%/147) are **'on track'** with 8 deliverables that are **'unlikely to complete on time/meet target'** (listed below).



The following table summarises the 8 red (unlikely to complete on time) deliverables, these will continue to be monitored throughout 2024/25. There are two red deliverables that relate to this committee (**in bold**).

Deliverable	Comment
Surge Capacity (RTP)	Timeline slippage for move from Ward 10 to Ward 6 due to completion of works and cleaning dates.
Development of a new OP specialist Gynaecology Unit	Approval of funding received from FCIG to commence architect commission and scope of work.
Delivery of New Laboratory Information system (LIMS)	Complete local implementation and secure revised timeline for national build, likely to be Q4 2024/25.
Increase capacity for providing in-hours routine and urgent dental care	Whilst we are beginning to see some signs of improved access to GDS, there are still limited GDS open to NHS Registrations. Work continues with Scottish Government to explore all options available locally, whilst contributing to national policy development/considerations.
Business Transformation (RTP)	Savings being delivered through Digital opportunities. However, limited assurance remains due to delays in the programme commencing.
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017)	Work is ongoing with senior leads in Acute and HSCP to improve target timeframes. However, the Directorates internal processes in relation to the complaint handling procedures requires further focus to improve consistency.
Hospital Pharmacy Redesign	Funding not available for large scale programme currently. Work to centralise procurement team and routes at VHK underway.
SLA and External Activity (RTP)	Ongoing discussion with NHS Lothian and NHS Tayside on financial planning assumptions.

This report provides the following Level of Assurance: (add an 'x' to the appropriate box)

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

	amount of residual risk or none at all.	moderate amount of residual risk.		

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

Workforce planning is key to the ADP process.

2.3.3 Financial

Financial planning is key to the ADP process.

2.3.4 Risk Assessment / Management

Risk assessment is part of ADP process.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been approved by Director of Finance & Strategy and Associated Director of Planning & Performance.

2.4 Recommendation

This Committee is asked to:

- **Decision** – approve submission of Q1 update and response to ADP feedback to Scottish Government
- **Assurance** – this report provides a moderate level of assurance.

3 List of appendices

- Appendix 1 - NHS Fife ADP 202425 - SG Feedback - Fife Response
- Appendix 2 - NHS Fife ADP 202425 Quarterly Report Q1

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

RE-FORM • TRANSFORM • PERFORM

Annual Delivery Plan 2024/25 SG Feedback - Response

Recovery Driver:	Primary and Community Care
Priority Areas:	None

SG Development and Improvement Feedback

It is welcome that the Board's plan shows their focus on the continuing development of multidisciplinary teams and dual nursing posts to ensure a sustainable OOHs service. This is encouraging and it will be helpful to hear details on the actions to develop these.

The plan states that the Mental Health and Wellbeing in Primary Care and Community Settings project started in late 2022 and is expected to run for 5 years. It states that core elements supporting coproduction are currently funded from Scottish Government. The plan states that due to the absence of funding the immediate focus will be on "quick wins" and the objective of MDT primary care teams is not sustainable due to funding. Scottish Government Primary Care and Mental Health colleagues have had recent conversations with NHS Fife regarding the pause of Mental Health and Wellbeing in Primary Care Services (MHWPCS) funding, but it would be helpful to ensure that the above is being delivered within existing resources and to confirm again that MHWPCS funding has been paused.

It would be helpful to see more content relating to General Ophthalmic Services, which is the core NHS service provided by optometrists.

The plan briefly references the Board's own locally funded and managed 'Glaucoma Shared Care Scheme' and then references "the national service" - which is the Community Glaucoma Service (CGS) - and the positive aspects this will deliver, including the use of the OpenEyes system to deliver the service. Scottish Government policy officials have been informed about the position that NHS Fife's eHealth team have adopted regarding the OpenEyes system, which is to decline to engage with any discussions about its deployment due to a demand for additional funding.

As Scottish Government policy officials have already advised the Health Board, this is an unacceptable position to adopt given both the current size of the hospital ophthalmology waiting lists and the legal position – Scottish Ministers have directed all Health Boards in Scotland to establish and operate the CGS in their areas, as per Paragraph 3 of The Optometry Enhanced Services (Glaucoma) (Scotland) Directions 2023.These issues will be picked up as the ongoing engagement between the Board and the relevant policy officials.

It would be helpful for the document to set out plan for rolling out the CGS in NHS Fife in 2024/25, including a timescale and an outline of how many patients it envisages being registered under the CGS (and therefore discharged off hospital ophthalmology waiting lists).

Fife Response

In line with the transforming urgent care and transforming nursing role programmes, the nursing infrastructure is now well established within primary care out of hours. Through implementation of the Primary care improvement plan and development of the in hours urgent care model, we are continually seeking opportunities to synergise and note your comments and will ensure the ADP updates reflects the progress being made.

Regarding the MHWBPC programme, we confirm that MHWBPCS funding has been paused and that all further activities are being delivered within existing resources. The initial project objective of MDT primary care teams is not deliverable due to the pause in funding in its current form. The programme has already carried out extensive participation and engagement, utilising a coproduction approach, with a significant response to this from our communities. This will guide future "quick wins" and longer-term developments within resources, these may include synergies with work already established via our strategic plans and workstreams.

Fife was regarded as a pathfinder when it successfully led a local initiative to establish shared care for people requiring management of glaucoma between secondary care and community optometry. In response to the statement regarding NHS Fife eHealth's position, a working group is established and exploring opportunities to deploy OpenEyes to enable the expansion of the programme. Due to the funding position, we are reviewing our modelling and will revise our planning and present via relevant groups and committees for decision. Fife HSCP remain committed to the continued expansion, and this will remain within our ADP as an objective and is also a key deliverable within our Primary Care Strategy's implementation plan 2023/26 for year 2 – 3.

Recovery Driver:	Urgent and Unscheduled Care
Priority Areas:	None specific to the plan itself; however the Board should continue to work closely with the Scottish Government Unscheduled Care Policy and Performance Team to drive improved performance.

SG Development and Improvement Feedback

The Board have outlined a clear set of trajectories which appear to be achievable. The plan provides a good level of detail on planned and current service development across the 5 portfolios of the Collaborative Program which will support performance improvement. The plan is also clear on the current financial position and highlights where service development may be affected by these challenges.

The Board describes the plans to deliver a 24-hour approach to Urgent Care, including further enhancements to the capacity and accessibility to HSCP-led Minor Injury Units (MIU) and Urgent Care Centres. It will be good to hear what these enhancements will be, and timescales for these plans, in relation to OOHs, recognising that the Board will be engaging with the relevant Scottish Government teams during 24/25.

Fife Response

Fife continues to monitor our agreed trajectories and have already taken supportive action to remodel how care is delivered within the Emergency Department utilising FNC and CBC redirections and alternatives to admission. This has been discussed with CfSD and led through our Integrated Unscheduled Care Programme Board (IUCPB).

Aligning to the Unscheduled Care Programme, Fife are currently reviewing our model for MIUs jointly between Acute and HSCP services. Following consultation and engagement and an options appraisal, recommendations will be presented via Committees for both the IJB and NHS Fife by Q3 of 2024/25.

The strategic focus will remain on delivering resilient and sustainable services which support care being delivered in the right place at the right time by highly effective multi-disciplinary teams, maximising resources, and technology. EQIAs and a robust communication plan will underpin any recommendations and implementations made to ensure no impact on equity and access to care. Advice and support are being taken from HIS presently regarding potential for major service change and planning will be based around the outcome of these discussions.

There is an integrated SLWG across Acute and HSCP chaired and co-chaired by both General Managers for each area with the oversight of the group being led by our IUPCB.

Recovery Driver:	Improve the delivery of Mental Health support and services
Priority Areas:	None immediately specific to the Delivery Plan; however, the Board should work with the Scottish Government Mental Health Team to drive improved performance.

SG Development and Improvement Feedback

The plan doesn't raise any new concerns and is reflective to the ongoing engagement between the Scottish Government and NHS Fife on mental health services. Each priority has been clearly outlined within the plan, and links directly to key priorities published in the National Mental Health and Wellbeing Strategy.

The following areas in particular will be the focus on ongoing engagement:

The demands on the CAMHS service remain high and additionally, national recruitment challenges present local challenges, thus impacting on progress in meeting the RTT target.

There is risk to future service delivery due to insufficient workforce capacity if the funding provided through national sources (Recovery and Renewal Fund & Community Framework fund) is no longer available or reduced in any way.

There is risk of not meeting RTT target if the service is unable to recruit or retain appropriately qualified clinicians to deliver complex care and treatment. A risk exists to staff wellbeing and morale if workforce numbers are reduced resulting in higher workloads and increased pressures.

Demand for psychological therapy remains high, analysis confirms that the service is not currently in balance, meaning that referrals currently exceed the number of treatments started that can be offered, limiting progress toward the RTT standard. The sustainability of service delivery is highly dependent on a resilient and effectively resourced workforce and any changes to the current national funding arrangements will impact on service delivery, and the ability to achieve targets and improvement plans.

Recruitment difficulties and service pressures affecting other parts of the system may reduce capacity for psychological interventions to be delivered by others.

Primary Care - The Mental Health and Wellbeing in Primary Care and Community Settings (MHWPCCS) project has a key objective, to deliver multi-disciplinary primary care teams and this is not sustainable in the absence of the planned funding. The immediate focus of the project will need to shift to ‘quick wins’ achievable within existing resources.

Fife Response

Fife HSCP welcome ongoing engagement with the Scottish Government Mental Health Team on the focus for CAMHS and Psychological Therapies.

The initial project objective of MDT primary care teams is not deliverable due to the absence of planned funding. The programme has already carried out extensive participation and engagement, with a significant response to this from our communities. This will guide future “quick wins” and longer-term developments within resources, these may include synergies with work already established via our strategic plans and workstreams.

Recovery Driver:	Recovering and improving the delivery of Planned Care
Priority Areas:	None immediately specific to the Delivery Plan; however, the Board should work with the Scottish Government Planned Care Policy and Performance Team on actions needed on their associated Planned Care Plan.
SG Development and Improvement Feedback	
Due to the significant financial pressure that all Boards are facing, there may be a consequent impact on waiting times performance. The Scottish Government will work with Boards to maximise options that bring most return for minimal cost.	
Fife Response	
An initial Waiting Times plan was submitted in Mar-24 covering 2024/25 trajectories with a revised plan re-submitted in Jul-24 following a finance review. The revised plan was delivered to NHS Fife FP&R Committee on 16th July. Waiting times are monitored through weekly meetings against the expected month end position which are currently on target. Waiting Times funding is being used differently with in-week list being funded to maximise efficiencies with staffing. Focus is on the longest waiting patients both for outpatient appointments and IPDC procedures.	

Recovery Driver:	Cancer
Priority Areas:	None immediately specific to the Delivery Plan; however, the Board should work with the Scottish Government Cancer Access Team to drive improved performance.

SG Development and Improvement Feedback

It is welcome that the plan clearly sets out the plans to improve Cancer Waiting Times for each challenged tumour group. Plan references Optimal Cancer Diagnostic Pathways for Lung and Head & Neck which will be reviewed in 24/25 with any improvements being cost neutral.

A Rapid Cancer Diagnostic Service (RCDS) pilot has been operational since Jun-21 but is only funded until Sep-24. The service has been running successfully, but NHS Fife will require additional funding to allow this service to continue after Sep-24. The plan states that the service is at risk if no additional funding is secured.

The radiology strategic plan is unfunded so a risk it will not deliver the additional imaging capacity required to support cancer pathways.

SPoC, prehabilitation, the psychological therapies and support framework, and the oncology transformation programme are all referenced, and assurances provided regarding involvement. This is welcomed, however additional references to CMPs would also be helpful.

Fife Response

Bids for the optimal pathways have been put forward through the DCE funding source whilst meetings to improve the lung cancer pathway continues with good progress made.

Optimised Lung and Head & Neck cancer pathways require ongoing capacity from Radiology for timely acquisition and improved turnaround times for reports. NHS Fife will endeavour to keep costs to a minimum but there will be revenue costs associated with this service improvement.

Funding for RCDS service has been extended until end of Mar-25 and the service will continue with no anticipated risk. Same/next day CT reporting diagnostic pathway will continue to be optimised to 7 days.

The projected capacity for Radiology is 22% greater than projected in 2023/24 due to additional non-recurring funding and mobile MRI allocation from the Scottish Government. The funding will enable delivery of 100% of patients waiting less than 2 weeks for urgent and USC (Urgent Suspicion of Cancer) imaging and 90% of patients waiting less than 6 weeks for a routine CT, MRI, or US scan. It is unclear if a similar level of additional funding will be made available in 2025/26 but Radiology leads are working in partnership with the National diagnostics lead to develop the strategic plan and identify associated costs.

Significant improvements have been made to reduce variance and waste across the Radiology system. Patient focussed booking has resulted in a reduction of DNA rates and short notice cancellation processes have been developed to ensure loss of capacity is monitored and managed.

The current Radiology Strategic Plan includes plans for additional CT/MRI and US equipment and workforce requirement to ensure sustainability and ability to meet growth in demand for diagnostic imaging and ability to prioritise USC. There is no identified funding source for this capital or revenue investment.

The PMB pathway is currently undergoing a review in line with the joint guidance regarding unscheduled bleeding whilst on HRT. The aim is to have 2 vetting options: USC and Urgent. Those vetted USC will be appointed as a priority, with significantly reduced waiting times once the new pathway is embedded.

SPOCH supports initiation of the pathway within existing resource. Cancer Waiting Times non-recurring funding has been agreed to support radiology activity for Q1 and Q2.

Regional working ongoing in respect of implementation of the CMPs.

Recovery Driver:	Health Inequalities
Priority Areas:	None

SG Development and Improvement Feedback

On Drugs and Alcohol Services, the plan makes reference to multiple services that should be delivered by delivery partners out with the Board. Whilst the references to the general ADP Strategic Plan and actions are extensive, they appear to be a straight lift from that plan, rather than an account of the specific actions the Board will pursue under that plan. It would be helpful to have more focus on the specific areas that the Board leads on.

Fife Response

Using MAT Standards funding, the NHS Fife Addictions in partnership with NHS Fife Addictions Psychology and Therapy Service have developed an innovative approach for the treatment and recovery of people physically and psychologically dependent on illicit benzodiazepines.

To support individuals to reduce their benzodiazepine use, those accessing the clinic are offered appropriate psychosocial interventions (e.g. Tier 1 & 2 interventions such as Decider Skills, Safety & Stabilisation, emotion regulation work, etc) in a timely fashion and the function of their problematic benzodiazepine use is understood via a psychological formulation. These interventions are offered alongside any planned reduction of their benzodiazepine use to provide the individual with a new, more effective set of coping skills and resources to manage their symptoms of anxiety, distress, and (for a significant number of patients) trauma which are likely to be more noticeable as the individual relies less on substances as a form of coping. The combination of evidence-based psychological interventions provided concurrently with a planned benzodiazepine reduction over time will increase the likelihood of successful long-term reduction in benzodiazepines use and ultimately contribute to a reduction in harm and drug related deaths. A third sector service has also been commissioned to offer community and wraparound support to patients and help them develop recovery-based skills.

Using MAT Standards Funding, NHS Addiction Service leads on the operational development of Rapid Access Clinics as part of our commitment to MAT1 (same day prescribing) and MAT5 (retention in services).

NHS Fife Addiction Services runs Rapid Access Clinics in several different locations across Fife. The purpose of the clinics is to provide a rapid response and intervention to individuals with alcohol and drug problems when indicated, reducing the risk of drug or alcohol related morbidity and mortality. These include:

- Initiating assessment and treatment within 24 hours of requesting treatment (meeting MAT1).
- Rapid re-engagement in treatment of patients recently disengaged with treatment.
- Rapid assessment of patients already in treatment with high and complex needs and urgent physical, psychiatric, or social comorbidities.
- Rapid assessment of patients recently discharged from hospital, facilitating seamless transition from hospital care to community care.
- Rapid engagement of individuals released from prison.

NHS Fife Addictions Psychology and Therapy Service operationally leads on a workforce development plan across all commissioned and statutory services of the Fife Alcohol and Drugs Partnership (FADP). This contributes to the delivery of MAT 6 and 10 but also provides skills and knowledge to work more effectively on trauma and with people affected by alcohol use too. In 2024/25, the training programme will complete the actions below:

- Development of social networks across FADP services (Dec-24)
- Regular coaching/supervision for staff in key evidence-based psychosocial interventions (business as usual).
- Tier 1 training to continue (business as usual).
- Appropriate staff to be identified for Tier 2 training, and Tier 2 training to commence by Mar-25.
- Voice of lived experience to be fed into MAT 6 and 10 work, through regular surveys of service user care (Sep-24)
- Trauma walkthroughs to be completed with all FADP services (Mar-25)
- On exploring staff wellbeing and measures (as per MAT10), focus that can be put in place to support (Jan-25)

Recovery Driver:	Child and Maternal Health
Priority Areas:	None

SG Development and Improvement Feedback

Plan expresses some concerns around delivery of continuity of carer, and it would be helpful to include more detail on this.

High level assurance is provided in relation to the delivery of child health reviews.

It is welcome to see plans to increase access to early pregnancy scanning out of hours and collaboration with Primary Care to develop a prescribing pathway for progesterone to be delivered within existing resource.

On the Women's Health Plan, the Board have identified a lead and a series of local priorities, though there are some concerns about whether these will be delivered upon due to financial challenges. It would be if the Women's Health Plan threaded through other areas of this plan such as the cardiovascular health section or health inequalities.

Fife Response

Following the extension of the implementation date of Women's Health Plan to Jun-26 and successful staff recruitment to vacant posts, the projection for the successful implementation of continuity of carer is now more positive and is predicted to be achieved within timeframe. The team are currently meeting monthly with the Director of Midwifery to update on progress and status.

NHS Fife NNU team participated in a meeting with the East Region planning group for the new model of Neonatal Care redesign (Best Start 2017) on 19 Jun. The meeting focus was to discuss the cot modelling outlined within the RSM report of Jun-24 where concerns were outlined regarding the proposed model of cots. The concerns highlighted will be taken forward to Regional Chair discussions for consideration.

The recommendation to reduce from 4 ICU cot capacity to 0.5 will not allow us to function as an LNU providing short-term intensive care and will impact negatively on our ability to care for women experiencing multiple and late-premature births. The recommendation will mean we will not be able to provide care for other levels of sick neonates and will negatively impact on our ability to repatriate babies back to our unit as we will not be able to fulfil the requirement of repatriation criteria as outlined within Best Start.

Following review of data for the period Dec-22 to Jan-24, based on assumption that we would be working on the RSM cot and ICU capacity, there would be over 100 women annually between 26- and 34-weeks' gestation who would require in utero transfer out with NHS Fife. In addition, the working assumption within the RSM Report is that for every 10 actual neonatal admissions there will be 6 maternal admissions. This assumption would mean that a further additional 60 maternal admissions would require transfer out with Fife. There are inherent risks to both a mother and foetus associated with in utero transfer.

Recommendation is that NHS Fife maintain the status quo in terms of current capacity and cot designation until Spring 2025. This would enable the units not yet implementing the premature pathway to commence. If NHS Lothian are assured of their capacity to accept transfers in, capacity could decrease to 15 total cots, 3 of which are ICU.

Recovery Driver:	Implementation of the Workforce Strategy
Priority Areas:	None immediately specific to the Delivery Plan; however, the Board should continue to work with the Scottish Government to drive closer alignment between workforce and delivery planning.

SG Development and Improvement Feedback

Plan and actions laid out by NHS Fife appear achievable and realistic and the Board has appropriate governance and plans in place.

NHS Fife's Delivery Plan provides sufficient high-level assurance of activity in relation to the implementation of the Workforce Strategy.

Fife Response

NHS Fife is continuing to implement the Board Workforce Plan for 2022-2025, in close collaboration with Planning & Performance, Finance and HSCP Workforce colleagues, pending receipt of the revised national workforce planning guidance.

The landscape has now changed with the commencement of the RTP Programme and the respective work streams.

Planning is underway for the impact of the non-pay elements of the 2023/24 AfC Pay Award, including the Reduction in the Working Week, the Band 5 Review of Nursing roles and the implementation of Protected Learning Time, with regular reporting to various fora within the Board.

Arrangements are in place for implementation of the Health and Care (Staffing) (Scotland) Act 2019, which is closely aligned to our eRostering Programme.

We have made good progress with enhancing our employability focus, including the new EMERGE programme. This is an initiative to encourage pupils at targeted schools an opportunity to gain a qualification through Fife College, whilst also gaining experience in a health care setting through placements, on-site visits, and speaker sessions.

In line with Improving Wellbeing and Working Cultures work on Equalities, our staff health & wellbeing support for staff and on Our Leadership Way is also progressing, with the launch of our LGBT+ Network in Jul-24.

Recovery Driver:	Digital and Innovation
Priority Areas:	None

SG Development and Improvement Feedback

Cyber resilience is a key area where the Board have updated against the cyber resilience framework as expected and remains of upmost importance. There is an on-going need to replace legacy systems across NHS Scotland and it is welcome to see that this is something highlighted as a key priority to ensure security and technical compliance.

It is welcome that the Board has set out clear activity to ensure the workforce and Executive team are skilled and informed regarding digital developments. Aligning a revised Digital and Information Strategy to the existing population health and wellbeing strategy will be a positive step.

It is helpful to see the key updates set out against national programmes including e-Rostering, HEPMA, GP IT, Child Health, Microsoft 365, and LIMS. The plan highlights a funding risk for e-rostering after Nov-24. All other programmes appear to be on track and considerations underway for how they prepare for developments including Digital Front Door, which is welcome.

Future iterations of plan should set out how the Board will implement the NHS Scotland Scan for Safety Programme by Mar-26 as mandated in the Scottish Government's Directors Letter (2024) 3.

Fife Response

Work continues on the development of the plan for the implementation of the NHS Scotland Scan for Safety Programme. Details will be provided into the plan at the end of 2024/25 Q2.

Recovery Driver:	Climate Emergency and Environment
Priority Areas:	None

SG Development and Improvement Feedback

Overall, the plan is effective at meeting the climate emergency and environment planning priorities.

Comprehensive response in relation to waste and resource management, showing a clear understanding of current performance and actions required. However, no Circular Economy detail is provided, and it would be useful to include information on this.

The Board provide and evidence how they are meeting the targets currently, have had gone beyond some of the initial targets set out, which is welcome. There is a system in place via WMSG at local level to be able to progress this work and have put resource into managing waste appropriately on site.

The Board is undertaking a landscaping project at their Queen Margaret Hospital site, which includes both biodiversity and adaptive interventions. The Board has also outlined their intention to undertake biodiversity audits for all main sites which will include total land area, greenspace area and indicate greenspace types.

The finding of this audit will inform the development of a Biodiversity Action Plan. They will continue to undertake works identified in their 2030 Greenspace Strategy. These actions are in alignment with the national agenda for this workstream.

The Board is taking a place-based approach to adaptation by collaborating with Fife Council to identify shared climate risks and adaptation measures. They also will be seeking to progress their CCRA through the creation of a risk dashboard that will align with their corporate level dashboard which has already been launched. They have also mentioned adaptive planting measures.

The Board is adopting a sensible approach to both fleet decarbonisation and sustainable and active travel, the latter having a dedicated strategy to be published in due course. The Board's fleet decarbonisation and replacement plans are well advanced, though as with all boards, it relies on central funding being made available.

NHS Fife will create a Building Energy Transition Strategy that aligns with PAMS to strategy review and invest in buildings that will be in the Board's longer-term portfolio. Using the Jacobs Net Zero Route maps, the Board will review decarbonisation measures outlined and create delivery plan and submit relevant funding applications while there are capital funding constraints.

The Board will need to ensure that they have a plan for Entonox mitigation. A clear program needs to be articulated Including project lead, occupational exposure monitoring for midwifery teams in conjunction with health and Safety and medical Physics. Improvement planned preventative maintenance by estates teams and stock management between pharmacy and soft facilities.

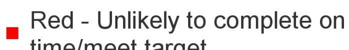
Fife Response

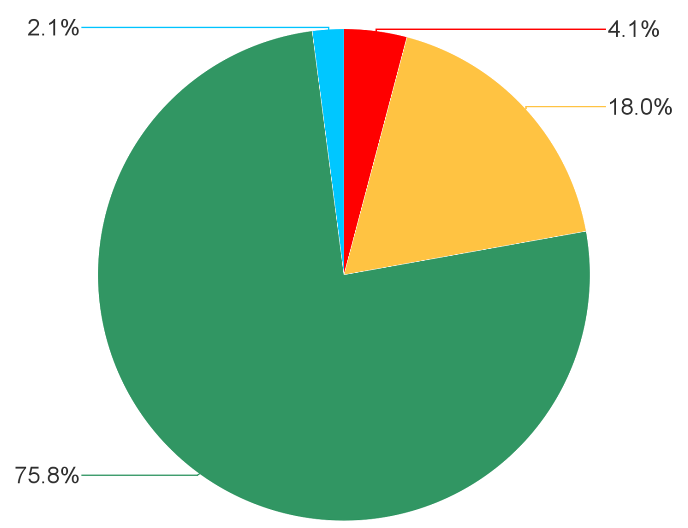
In terms of circular economy, NHS Fife launched the 'warp-it' system in March 2024. Warp-it is a web service and re-use platform, for redistributing surplus furniture and equipment. We are keen to get warp-it set up at NHS Fife as an efficient method of managing the flow of surplus assets across the NHS Fife estate and ensuring items are reused instead of sent to waste disposal where possible. Since its launch, it has over 450 members and has incurred over £39k in savings. We will continue to roll out the warp-it system, increasing its use and resultant environmental and financial benefits.

NHS Fife has an Entonox mitigation SLWG in place, led by the chair of the local medical gas committee. It is multi-disciplinary including clinicians, medical physics, estates, health and safety, and pharmacy. The Fife Quality Improvement Network have been approached to support in a programme capacity. A systems loss assessment within midwifery department is going ahead in Jul-24 – this will drive additional actions. Work is ongoing with midwifery around monitoring, and the team are working with the established national forum.

Annual Delivery Plan 2024/25 Progress Summary

Q1 Status	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met	Total
1. Primary and Community Care	1	5	16	1	**23**
2. Urgent and Unscheduled Care	1	3	11		**15**
3. Mental Health		3	15		**18**
4. Planned Care			9		**9**
5. Cancer Care		1	5		**6**
6. Health Inequalities		3	24	1	**28**
7. Women & Children Health	1	3	8	1	**13**
8. Workforce		1	15		**16**
9. Digital & Innovation	2	6	11		**19**
10. Climate		1	11		**12**
Other	3	9	22	1	**35**
To Improve Health and Wellbeing	1	6	29		**36**
To Improve the Quality of Health and Care Services	2	10	64	2	**78**
To Improve Staff Experience and Wellbeing		5	15		**20**
To Deliver Value & Sustainability	5	14	37	2	**58**
ALL			2		**2**
Total	**8**	**35**	**147**	**4**	**194**





Annual Delivery Plan 2024/25 Progress Summary

RTP

Deliverable	Directorate	2024/25 Q1 Comment	2024/25 Q1 Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status
Business Transformation	Digital	Savings being delivered through Digital opportunities. However, limited assurance remains due to delays in the programme commencing.		To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target
SLA and External Activity	Finance & Strategy	Ongoing discussions with NHS Lothian on financial planning assumptions and the implications of the introduction of PLICS. NHS Fife have engaged with Scottish Government and plan to implement PLICS locally by December 2024. Ongoing discussion with NHS Tayside on financial planning assumptions. Deep dive commenced into referral volumes by locality and specialty. Clinical leads fully engaged in this review and proposals for repatriation of a small number of services in development.	Extrapolation of data on outpatient activity in other boards complete Initial and subsequent deep dive of data Discussions with clinical leads and directors Draft Performance Management group TOR developed	To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target
Surge Capacity - Improve flow within the VHK site, reducing length of stay and number of patients boarding to ensure patients are looked after in the most appropriate setting. Accurate PDD to inform planning for discharge, coordinated with the Discharge Hub.	Acute Medical	Acute are operating at winter-level pressures continuously. Despite this, occupancy below expected target levels and progress remains positive. If investment is not available to recruit to substantive nursing and consultant posts to manage surge beds, then this scheme will not achieve the savings outlined. Timeline slippage for move from Ward 10 to Ward 6 due to completion of works and cleaning dates.	Length of stay meetings continue. Overall surge is reduced. Improved discharge planning, fully utilising an MDT approach and PDDs. Implementation of ward access targets.	To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target

Deliverable	Directorate	2024/25 Q1 Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation	Workforce	Considering redeployment to support the transition into a staff bank from existing system cost pressures	To Deliver Value & Sustainability	Amber - At risk - requires action
Procurement Savings within Acute Services	Acute Services	Implementation plan in place and a range of projects underway.	To Deliver Value & Sustainability	Amber - At risk - requires action
Estates Rationalisation	Property & Asset Management	Hayfield House closed. Agile solutions in place at Queen Margaret, Lynebank, VHK staff club (St Andrews and Adamson Hospital to follow shortly).	To Deliver Value & Sustainability	Green - On Track
Infrastructure - RTP	Digital	Development of Asset Management Approach Implement approach	To Deliver Value & Sustainability	Green - On Track
Infrastructure - Workforce	Digital	Provision Lynebank Decommission Hayfield	To Deliver Value & Sustainability	Green - On Track
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets	Pharmacy & Medicines	Production of comprehensive communications plan to enhance optimisations work on all sides, involving a wide range of stakeholders including patients and clinicians, including medicines waste. Significant design and delivery work undertaken, including of targets and identification of staffing resource. Medicines waste campaign being developed, including updated materials	To Deliver Value & Sustainability	Green - On Track
Non-compliant Rotas	Medical Directorate	Recruitment and interviews complete, and candidates selected for Gateway EU Doctors joining August cohort. Revised medical rotas received final approval to go live for August cohort at 1A banding. Surgical rotas previously band 3 have had final approval to return to 1A banding for August cohort. Wellbeing & Engagement SLWG has drafted FAQ's, Induction information is currently being reviewed for use by SLWG.	To Improve the Quality of Health and Care Services	Green - On Track

Annual Delivery Plan 2024/25 Progress Summary

To Improve Health and Wellbeing

Deliverable	ADP Reference	2024/25 Q1 Comment	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Increase capacity for providing in-hours routine and urgent dental care	1.5	Whilst we are beginning to see some signs of improved access to GDS, there are still limited GDS open to NHS Registrations. Locally, there are limits on what we can do to influence this, in particular due to Fife having a significant amount of GPDs managed by Dental Body Corporates. however we are working with Scottish Government to explore all options locally available, whilst contributing to national policy development/ considerations.		1. Primary and Community Care	Red - Unlikely to complete on time/meet target

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Work to address poverty, fuel poverty and inequality through ensuring the prioritisation of income, housing, education and employment programmes as part of the Plan 4 Fife.	6.4	Contributing to Fife housing partnership ending homelessness together priority group pathways. Completed needs assessment for housing of young people experiencing substance misuse issues. Contributing to opportunities Fife partnership priorities.	6. Health Inequalities	Amber - At risk - requires action
Improved Fife-wide ADHD pathways for children & Young people	7.1		7. Women & Children Health	Amber - At risk - requires action
Deliver the child aspects of Fife Annual Poverty Plan with Fife Council and other partners.	7.3	Influence NHS Fife Anchor Strategy to focus ambitions relevant to child poverty Support NHS actions including income maximisation for pregnant women and parents of under 5s; explore expansion to community child health services	7. Women & Children Health	Amber - At risk - requires action
National - Child Health Replacement	9.1		9. Digital & Innovation	Amber - At risk - requires action
Deliver a more effective BCG and TB programme. Public Health Priority 1 and 2				Amber - At risk - requires action
Fife will eliminate Hepatitis C as a public health concern. (Pre COVID target by 2024. Extension of date under consideration by SG)		Develop initial plans, in conjunction with national direction	1. Primary and Community Care	Amber - At risk - requires action
Carry out focused work to make sure we proactively improve access and uptake of vaccinations across our whole population	1.2	EQIA action plan implementation	1. Primary and Community Care	Green - On Track
Improve access for patients and carers through improved communication regarding transport options	1.7	Actions in action plan being progressed	1. Primary and Community Care	Green - On Track
Home First: people of Fife will live long healthier lives at home or in a homely setting	2.6		2. Urgent and Unscheduled Care	Green - On Track
CAMHS will build capacity in order to deliver improved services underpinned by these agreed standards and specifications for service delivery.	3.1		3. Mental Health	Green - On Track
CAMHS will build capacity to eliminate very long waits (over 52 weeks) and implement actions to meet and maintain the 18- week referral to treatment waiting times standard.	3.1	Fife CAMHS Early Intervention Service will build sustainable programmes of training and development to universal and additional service providers to ensure clear pathways of support are available and accessible across the spectrum of need. Fife CAMHS will ensure that a recurring recruitment programme is in place so that the workforce is maintained at full capacity. Fife CAMHS will continue to work towards achieving the standards set within the National CAMHS Specification, prioritising the development of specific clinical care pathways, improving access and response out of hours and service appraisal through improved service user participation and engagement.	3. Mental Health	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Partners within Fife HSCP will continue to build capacity across services in order to achieve the standards set within the National Neurodevelopmental Specification for children and young people	3.1		3. Mental Health	Green - On Track
Refreshed Mental Health and Wellbeing Strategy for Fife for 2023 - 2027	3.2	Review of national situation, and national drivers identified. STEEP analysis of external environment. SWOT analysis of internal environment. Review and evaluation of the previous Mental Health Strategy (2020-2024) Collated financial budgets to produce an integrated overview of the Partnership's mental health services. Developed a first draft of new Mental Health and Wellbeing Strategy.	3. Mental Health	Green - On Track
Develop and maintain an integrated community drop-in model provided by specialist Alcohol and Drug Teams and community services and partners. Focus on locality data, voices of local communities and services to repeat the process of locality-based service development	6.2	Review recent alcohol/drug related death and harm including hospitalisation data published nationally and local data from ADP services to support planning for next one stop shops (KY Clubs). Attend relevant locality boards to present data and prioritisation for locality based approach Continue to review and evaluate progress of KY2 and KY5 one stop shops with subgroup of HSCP Locality Board Launch of additional one stop shop in Kirkcaldy in partnership with local third sector organisations	6. Health Inequalities	Green - On Track
Localities exist to help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement.	6.2	Finalise alert process and protocol with PH to be approved by ADP Committee in June 2024 Perform live test of protocol to manage next alert Conduct lessons learned to refine process and ensure fit for purpose	6. Health Inequalities	Green - On Track
Public Health Priority 4: National Drugs Mission Priorities; MAT treatment standards; Fife NFO strategy; Fife ADP strategy	6.2	Public Health provided advice on the content and implementation of ADP Annual Delivery Plan, continued to provide input to the MDDRG and contributed to associated actions and provided input to the Addressing Alcohol Harm and Death Group.	6. Health Inequalities	Green - On Track
Child and Adult weight management programmes: Develop a sustainable workforce within the resources available via regional funding award	6.3		6. Health Inequalities	Green - On Track
Develop and maintain Smoking Cessation services	6.3	Specialist clinical provision increase in most deprived areas in collaboration with community assets. Raise awareness of abstinence model with smoking cessation site access. Mobile unit to target local community venues to be visible and accessible in supporting local groups/events with appropriate networking. Maintain and establish connection to Fife maternity Services to capture early intervention of possible referrals at first point of contact with midwives. Delivery of smoking related training sessions through Health Promotion Training Programmes. Evaluation and review of current referral pathways into the service, develop if needed accessible pathway and plan campaign to raise awareness of any changes. Investigate and assess system for inpatient clinics and discharge hubs to have an opt out referral pathway to service (mirroring maternity referral pathway) for smoking related illnesses.	6. Health Inequalities	Green - On Track
Support the implementation of the Food 4 Fife Strategy and associated action plan as part of ambition to make Fife a sustainable food place	6.4	Final draft strategy presented to Fife Council Cabinet Committee in May and to EDG and Public Health and Wellbeing Committee June and July	6. Health Inequalities	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Work with the Chief Executive of NHS Fife to establish NHS Fife as an Anchor Institution in order to use our influence, spend and employment practices to address inequalities.	6.4	Continue to scope out opportunities whilst working through NHS Anchor strategic objectives. Continue to work with partners to scope opportunities and engagement relating to child poverty and the priority areas. Employability engagement sessions and future programmes are being developed. Links with partners are being strengthened to support ambitions. Continue to explore opportunities and promote Community Benefits Portal to attract bids. Employability and Community Wealth Building workshop is in early planning stage to strengthen our partnership working and also with third sector agencies and community planning groups. Progression framework being updated to evaluate progress within employability, procurement and land and assets pillars. The findings will be presented to ~Anchor Institution Programme Board in September 2024.	6. Health Inequalities	Green - On Track
Localities exist to help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement.	6.5	The Locality Delivery Plans to be reviewed and signed off by locality groups at June meetings. Locality Progress report presented to 7 area committees outlining outcomes achieved in 2023 and highlighting any areas of joint working with community planning partners.	6. Health Inequalities	Green - On Track
Contribute to NHS Fife's High Risk Pain Medicines Patient Safety Programme to support appropriate prescribing and use of High-Risk Pain Medicines and ensuring interventions take into consideration the needs of patients who are at risk of using or diverting High Risk Pain Medicines.	6.7	Provide public health perspective on HRPM Patient Safety Programme Board - Programme Board Transitioned to HRPM Safety Group - PH Representation on this group Advise and support evaluation aspects of HRPM Patient Safety Programme - Benefits/Evaluation Framework agreed and signed off HRPM Patient Safety Programme stopped earlier than planned due to organisational financial challenges - areas of work will transfer to business as usual - support from PH re evaluation work will continue	6. Health Inequalities	Green - On Track
Design and delivery of a comprehensive medicines safety programme for NHS Fife, enhancing the safety of care and ensuring the Board meets its obligations to Scottish Government direction	6.7	Establishment of all working groups is now complete Establishment of medicines safety and quality policy group with 8 weekly reporting cycles - complete Establishment of medicines safety minute index - completed	6. Health Inequalities	Green - On Track
Review existing wellbeing indicator collection data to develop multi-agency response in line with GIRFEC framework.	7.1	Conduct multi-agency review of collated wellbeing indicators.	7. Women & Children Health	Green - On Track
Work with local authorities to take forward the actions in their local child poverty action report	7.3	The reporting data for April 2023- March 2024 is being prepared as part of the annual reporting for Fife Poverty Report. An SBAR will be prepared specifically on the income max pathway and also the poverty training element. Training has been scheduled for key staff groups. A new funding bid has been submitted for continuation dedicated money advisor post	7. Women & Children Health	Green - On Track
Growth of OH services and establishment of resources to assure function sustainability meets the changing needs of the organisation and supports the delivery of care goals through a variety of services including mental health / wellbeing / fatigue management support	8.3	Continue to review OH provision as part of Directorate service change proposals, taking account of succession planning, service resilience and business requirements.	8. Workforce	Green - On Track
Children's speech, language and communication development Plan		Having identified the relevant strategic strands within the Children's Services plan start to raise awareness of the need for a speech, language and communication development plan linked to their outcome measures. Understand the national action plan and what this means for Fife by involvement in local event - Creating the Conditions: Connecting people to nurture early communication.	7. Women & Children Health	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Deliver an effective public health intelligence function to provide multifaceted high-quality intelligence that supports the portfolios of work within Public Health and supports the strategic development, policymaking and the planning, delivery, and evaluation of services within NHS Fife and its partners.		Public Health Intelligence have lead or contributed to a range of projects across the six Public Health priorities including child health and wellbeing, alcohol and drug hospital admissions and mental health.	6. Health Inequalities	Green - On Track
Develop and Enhance Children's Services		Fife Child wellbeing pathway refresh, guidance update and multiagency training commenced (GIRFEC)	7. Women & Children Health	Green - On Track
Development of improved digital processes i.e. online pre-employment and management referral programmes		Extension of current OH System contract. Scoping activity being undertaken supported by D&I.	8. Workforce	Green - On Track
Ensure effective coordination and governance for adult screening programmes in Fife		Investigation and management of screening programme incidents and adverse events, including the National Cervical Exclusion Audit. We progressed the National Cervical Exclusion Audit in Fife by auditing over 4,000 patient records, and coordinated clinical management of patients referred to their General Practice or to gynaecology.	6. Health Inequalities	Green - On Track
Ensure effective direction and governance for the delivery of immunisation programmes in Fife and provide assurance that the Fife population is protected from vaccine preventable disease.		AISG met 03/06/24 and reviewed annual childhood data and approved annual report. Annual Immunisation Report submitted to Public Health & Wellbeing Committee at meeting 01/07/24 along with refreshed Strategic Framework 2024 - 2027	6. Health Inequalities	Green - On Track
Remobilise Smoking Cessation services with a view to achieving 473 quits in FY 2023-24		Development work is being progressed to maximise successful quit attempts and retaining client contact with the service. Specialist service provision has increased across Fife: 28 community-based, & 15 GP/ hospital-based clinics.	1. Primary and Community Care	Green - On Track
To embed a working business continuity management systems process that is measurable and able to be easily monitored.		Compliance and performance metrics is reported quarterly through the Resilience Forum	2. Urgent and Unscheduled Care	Green - On Track
Work with partners to increase efforts to reduce the impact of climate change on our population.		Develop training plan for sustainability within NHS Fife. Develop communications plan for sustainability e.g. Green Health Week. Green Health Partnership funding application has been submitted with an expected outcome November 2024. Local development plans for spatial planning meeting arranged to contribute to the "The place matters" call for sights and ideas, within the local development plan. Continue to contribute to LDP project delivery group following the review of LDP governance and delivery arrangements.	10. Climate	Green - On Track

To Improve the Quality of Health and Care Services

Deliverable	ADP Reference	2024/25 Q1 Comment	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets		The Patient Experience Team continues to review their own internal processes and work is ongoing with senior leads in acute and HSCP to improve target timframes. However the Directorates internal processes in relation to the complaint handling procedures varies.			**Red - Unlikely to complete on time/meet target**
Development of a new OP specialist Gynaecology Unit	7.2	Approval of funding from FCIG to commence architect commission and scope of work.		7. Women & Children Health	**Red - Unlikely to complete on time/meet target**

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Digital / Scheduling: Digital systems will be enhanced to realise full potential of integration across health and social care	2.1		2. Urgent and Unscheduled Care	**Amber - At risk - requires action**
Expand on current system wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models	2.1		2. Urgent and Unscheduled Care	**Amber - At risk - requires action**
Fife Psychology Service will increase capacity to improve access to PTs, eliminate very long waits (over 52 weeks) and meet & maintain the 18 week referral to treatment waiting times standard	3.1	Review processes in line with Psychological Therapies and interventions specification and reporting guidance. .	3. Mental Health	**Amber - At risk - requires action**
Review of Specialty Paediatric Nursing workforce/ services (including Diabetes, Epilepsy, Rheumatology, Endocrinology, Respiratory, Cystic Fibrosis) in line with safer staffing legislation and Working Paper 8 "Review of Clinical Nurse Specialist roles within Scotland" of the Scottish Governments Transforming Roles Program.	7.1	Review of service and redesign complete. CF nurse is now B7 team lead for specialist nurses with a generic B5 to support across all areas during periods of absence. Diabetes JD band review from 6-7 not upheld pre covid. Temporary uplift agreed in Q4 with funding only for 3 months.	7. Women & Children Health	**Amber - At risk - requires action**
Committed to controlling, reducing and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) in order to maintain individual safety within our healthcare settings.		Finalise MEG business case and support implementation Complete recruitment process for IPC Audit and Surveillance - dependancy on HR/Recutiment and Banding of post Review IPC Education Starategy - in progress Publish IPC Education/Training Programme 2024/25 - in progress World Hand Hygiene Day promotion and launch of "gloves off" campaign - completed		**Amber - At risk - requires action**
Contribute Public Health perspective and evaluation support to Fife's Mental Health Strategy Implementation Group.			3. Mental Health	**Amber - At risk - requires action**
Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences		Recruiting 2 x volunteers to support the gathering of patient feedback initiaitves and Care Opinion. PET Officers have also started visiting the clinical areas to gather patient stories. Testing new investigation template (statement memo) within Medical Directorate to support quicker completion of complaint statements		**Amber - At risk - requires action**
Implement IP Workforce Strategy 2022-24		Continue bi-monthly LISDP Steering Group, reporting via ICC - continues Review recruitment and retention challneges in IPC, ICD and AMR- ongoing	1. Primary and Community Care	**Amber - At risk - requires action**
Implement new referral management and electronic patient records system (TrakCare/morse) within P&PC Physiotherapy service.			1. Primary and Community Care	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Implement preventative podiatry service in care homes		Development of job descriptions, recruitment of staff	1. Primary and Community Care	Amber - At risk - requires action
Ongoing development of Community Treatment and care (CTACT) services, supporting more local access to a wider range of services.	1.2	Working with Podiatry to bring all Low-Risk foot screening under the responsibility of CTAC Services. Working with ENT and Audiology services to develop joint Ear Care strategy. Delivery of leg ulcer specialist clinics. Development of an integrated workforce with our Community Immunisation Service, along with closer working across a wider Primary Care nursing team.	1. Primary and Community Care	Green - On Track
Targeted actions to improve the quality of our Immunisation services	1.2	Development of robust clinical pathways and process of SOP review	1. Primary and Community Care	Green - On Track
Ensuring there is a sustainable Out of Hours service, utilising multi-disciplinary teams.	1.3	Establish and test an Urgent Care Hub functioning over a 24-hour period to accept a high referral rate of urgent care referral to reduce same day urgent illness presentations within primary and secondary care.	1. Primary and Community Care	Green - On Track
Work with Secondary care to develop shared care initiatives to continue to reduce the requirement for patients to attend ED	1.6	Review and assess the role and impact of FICOS on supporting secondary and secondary care models	1. Primary and Community Care	Green - On Track
Develop and scope an SDEC model of care to support same say assessment and increase our ambulatory models of care.	2.2	Stakeholder engagement workshops complete. Development of PID to support transformational savings. Start to develop scheduling of USC pathway for ambulatory patients to support avoidance of admission.	2. Urgent and Unscheduled Care	Green - On Track
Increase redirection rate utilising flow and navigation (NHS 24 78%, GP 19%).	2.2	Increased CBC calls. SLWG set up for scheduling of USC. Clinical Leads for Acute and HSPC and Primary Care involved.	2. Urgent and Unscheduled Care	Green - On Track
Delivery of Care at Home / Commissioning: Maximise capacity, and commission and deliver care at home to meet locality needs	2.3	Oversight group to be re-set up - reviewing ToR for group and membership	2. Urgent and Unscheduled Care	Green - On Track
(Reducing the time people need to spend in hospital by promoting early and effective discharge planning and robust and responsive operational management)	2.5	Reduce delayed discharge by further embedding Planned Day of Discharge using a criteria led discharge approach H@H In-Reach Analyse TOC data and requirements for a permanent model. Recruit permanent post(s). Fife Rehab Model/D2A Model Establish workstreams and associated SLWGs Agree ToRs and membership Agree driver diagram Determine key deliverables and outcomes and plan how these will be achieved. Right Care for You: enhanced training available; purchase of specialist equipment Fife Rehab Model/D2A Model Review data available and undertake strategic needs assessment to determine optimal community rehab team staffing skill mix and numbers Develop appropriate D2A pathways and undertake Toc as appropriate	2. Urgent and Unscheduled Care	Green - On Track
Community Rehab & Care: To develop a modernised bed base model in Fife that is fit for the future	2.6		2. Urgent and Unscheduled Care	Green - On Track
Digital / Scheduling: create a centre of excellence for scheduling across community services	2.6		2. Urgent and Unscheduled Care	Green - On Track
Prevention & Early Intervention: new models of care ensuring early discharge and prevention of admission, and local frameworks for frailty	2.6	Enhance skills in Community Nursing to further support early discharge and prevention of admissions through administration of IV antibiotics Review current pathways between services to identify 1) gaps in provision and 2) overlap in resource Develop referral pathways between services to ensure increase & decrease of input level dependent on need to prevent readmissions to acute services	2. Urgent and Unscheduled Care	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Development and Implementation of an Adult Neurodevelopmental Pathway with clear links to CYP NDD Pathway.	3.1	Outcomes of Adult NDD Pilot project will be collated. Outcome report will include recommendations for pathway development and service delivery.	3. Mental Health	Green - On Track
Improve compliance with CAPTND dataset	3.1	On-going work with e-health & data analysts to build appointment management system that meets requirements.	3. Mental Health	Green - On Track
Reprovision of unscheduled care/crisis care provision for patients presenting out of hours with a mental health crisis	3.1	Revision to Project Brief to condense timeline. Phase 2 of work to develop KPIs - co-chair now linked with national MHUC Network. Benchmarking now in progress.	3. Mental Health	Green - On Track
Community Mental Health Teams for Adult and Older Adult services that are responsive to need and reduce admission by offering alternative pathways	3.2	CMHTs in Fife require further development - review of current provision and requirements to support improved service delivery Consistency across CMHTs in process and procedures achieved Longer term engagement with Alternatives to Admission pathway throughout 2024/25	3. Mental Health	Green - On Track
CAMHS will achieve full compliance with CAMHS and Psychological Therapies National data set and enhance systems to achieve compliance.	3.3		3. Mental Health	Green - On Track
Mental Health and Wellbeing in Primary Care and Community Settings - development and delivery of service provision in line with Scottish Government reports and planning guidance relating to the remobilisation and redesign of MH services.	3.3	Collation and reporting of coproduction work in 3 Localities; initial identification of areas for positive change .	3. Mental Health	Green - On Track
Fife Mental Health Service will work alongside partners in acute services, primary care services and third sector agencies to ensure robust and equitable pathways of care are in place for those in police custody and for those transferring into the community from prison.	3.4	Ongoing review and enhancement of the Fife multi-agency Mentally Disordered Offender Protocol to ensure that mental health assessment and support is coordinated through police custody and court liaison Delivery of multiagency training programme on mental health management and legislation	3. Mental Health	Green - On Track
Forensic Mental Health services are reviewed and restructured to ensure appropriate pathways that enable patient flow and maximise rehabilitation and recovery.	3.4	Meetings planned to discuss flow workstreams and remodelling clinical use of the rehabilitation facilities	3. Mental Health	Green - On Track
Improve the mental health services build environment and improve patient safety	3.6		3. Mental Health	Green - On Track
Delivering year on year reductions in waiting times and tackling backlogs focusing on key specialities including cancer, orthopaedics, ophthalmology, and diagnostics.	4.1	Weekly monitoring through waiting times groups with governance reporting structures in place. Q1 trajectories being met in the majority of specialties, but monitoring required in Urology.	4. Planned Care	Green - On Track
Enhance Theatre efficiency	4.1	Establishment of Theatre Utilisation Group that will meet fortnightly to monitor utilisation and specialty variances.	4. Planned Care	Green - On Track
Enabling a “hospital within a hospital” approach in order to protect the delivery of planned care.	4.2	Daily review of cancellations and bed capacity tracking. Fortnightly review of theatre utilisation projections. Weekly monitoring of capacity to deliver trajectories.	4. Planned Care	Green - On Track
Maximising Scheduled Care capacity	4.3	Utilisation of NRAC money to support increased capacity. Monitored weekly through waiting times meetings wit monthly oversight through Scheduled Care and IPCPB.	4. Planned Care	Green - On Track
Develop, Enhance and re-invigorate Regional Networks	4.4	OMFS no issues Plastics plan in place for additional operating Vascular network remains in place - ongoing recruitment to Fife vacancy. National review of vascular pending.	4. Planned Care	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Extending the scope of day surgery and 23-hour surgery to increase activity and maximise single procedure lists.	4.5	Weekly identification of cases suitable.	4. Planned Care	Green - On Track
Implement outcomes of Specialist Delivery Groups including reducing variation.	4.6	ACRT expanding in all specialities and clinical teams supporting development of information.	4. Planned Care	Green - On Track
Undertake regular waiting list validation.	4.7	Patient Hub project working alongside NECU validation to ensure all patients on lists require to be seen. Targeting key specialties with long waits including Orthopaedics and ENT	4. Planned Care	Green - On Track
Ensure people have clear information and are sign posted to the HSCP Wells to enable tailored access to support via a 'good conversation', while awaiting a secondary care appointment / treatment.	4.8	Agree a robust communication plan, working with services to optimise proactive support and sharing of information about the HSCP Wells NHS Inform waiting well pages. Acute supported through Patient Hub text project for waiting list validation.	4. Planned Care	Green - On Track
Begin preparation to review the 2022-25 Cancer Framework in NHS Fife to ensure still relevant and up to date	5.1	Updated the workforce section. Aligned the NHS Fife actions to the Cancer Action plan for Scotland 2023-26.	5. Cancer Care	Green - On Track
Update cancer priorities and develop associated delivery plan as outlined in the Cancer Framework and support delivery of the 10 year Cancer Strategy	5.1	Meetings with the services underway.	5. Cancer Care	Green - On Track
Expanding Endoscopy capacity and workforce	5.2	Waiting times for endoscopy well within trajectories	5. Cancer Care	Green - On Track
Review of actions outlined in the Framework for Effective Cancer management to improve delivery of Cancer Waiting Times	5.3	Actions identified for this year but awaiting the Framework being refreshed by the Scottish Government.	5. Cancer Care	Green - On Track
MAT based outcomes embedded in all ADP service level agreements. The standards implemented and fully maintained and PHS assessment supports this	6.2	Analyse and understand experiential data from 2023/24 from 58 service users, 12 family members and 16 staff Develop MAT Standards Plan for 2024/25 for sustaining MAT 1 to 5 and improving MAT 6 to 10	6. Health Inequalities	Green - On Track
Preventing alcohol specific and drug related harm and death affecting children and young people	6.2	Establishment of a rapid action group reporting to the Senior Leadership Team of the HSCP including representation from Education, Children Services, CPC, Community Children Services, Third Sector, Primary and Preventative Care Services Action Plan developed to include communications awareness raising approach, harm reduction messaging, improvements in referral pathways and responses, engagement and retention and services and workforce development to protect children and young people etc	6. Health Inequalities	Green - On Track
Best Start 1. Full implementation of Continuity of Carer by 2026 2. Minimising separation of late preterm and term babies from birth 3. Recommencement of full Antenatal Education 4. Expand Service User Feedback 5. Review need and gaps for, and embed Psychological services	7.1	Continuity of carer: Ongoing review of community team caseloads and care pathways alongside data review with requirements identified Antenatal Education: test of change commenced Neonatal redesign-Best start: NHS Fife NNU team participated in a meeting with the East Region planning group for the new model of Neonatal Care redesign (Best Start 2017) on 19 Jun. The meeting focus was to discuss the cot modelling outlined within the RSM report of Jun-24 where concerns were outlined regarding the proposed model of cots. The concerns highlighted will be taken forward to Regional Chair discussions for consideration.	7. Women & Children Health	Green - On Track
Develop mechanism for Health Visiting data analysis to assist partnership working with associated agencies, ensuring early intervention measures and anticipatory care needs are identified expeditiously.	7.1	Analyse existing data received from current Health Visiting pathway.	7. Women & Children Health	Green - On Track
To meet the recommendations of the WHP by end Dec 2024	7.2	Ongoing implementation and review of WHP recommendations with particular focus on Endometriosis: Commencement of endometriosis nurse specialist to support women going through induced menopause. Signposting of women who have not completed their surgical journey to the Sore - Know More campaign to support pain management and understanding of the pain process,	7. Women & Children Health	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Engage with Higher Education Institutions locally and regionally to develop collaborative way of working	9.5	Organise meetings with strategic leaders from University of St Andrews on Joint, collaborative working and develop areas of focus for collaborative working	9. Digital & Innovation	Green - On Track
Local - Implement Paperlite / Electronic Patient Record	9.61	Agree E.H.R Plan	9. Digital & Innovation	Green - On Track
Continued development of digital front door for patients	9.62	Extension of Waiting List Validation	9. Digital & Innovation	Green - On Track
Set out approach to implement the Scottish Quality Respiratory Prescribing guide across primary care and respiratory specialities to improve patient outcomes and reduce emissions from inhaler propellant	10.82	Receipt of guide from Scottish Government	10. Climate	Green - On Track
Comply with the requirements of the COVID enquiry; Operation Koper, Crown Office.		Provide information as requested by Police Scotland, liasing with the Care Home Collaboratived		Green - On Track
Deliver an effective health protection function, including in- and out-of-hours duty cover to prevent and respond to communicable disease prevention.		Provide a 24/7 specialist health protection service for Fife	1. Primary and Community Care	Green - On Track
Deliver a VAM Covid response in alignment with SG guidance and in collaboration with East of Scotland workforce with full investigatory and outbreak management and community testing functions.		VAM Plan document from PHS to remain in place, funding to achieve this confirmed; recruitment ongoing	1. Primary and Community Care	Green - On Track
Delivery of Clinical Governance Strategic Framework		Development of 2024/2025 workplan		Green - On Track
Delivery of Clinical Governance Strategic Framework - Adverse Events		Refreshed trigger list and new approach for SAERs, LEARs and CCRs		Green - On Track
Delivery of the objectives set within the Pharmacy and Medicines Strategic Framework for 2024-2026		Publication, and engagement within the Directorate Reporting process within Pharmacy PSLT developed Workplan for the first year at late stage of development	8. Workforce	Green - On Track
Delivery of the Risk Management Framework		Development of 2024/2025 workplan Review Board's risk appetite Policy to be incorporated in the Risk Framework		Green - On Track
Develop a Nursing and Midwifery Strategic Framework 2023 - 25; establishment of shared governance model Framework based on CNO and NHS Fife priorities, Recover to Rebuild, Courage of Compassion, Three Horizon Model		Shared Governance Model established with over-arching Professional Leadership Council and 5 sub councils. Review of band 7 and band 8 N&M staff commenced as part of workforce planning and framework development	8. Workforce	Green - On Track
Development of Medical Education Strategic Framework		First draft of framework complete		Green - On Track
Implement national Excellence in Care (EIC) objectives within NHS Fife In line with 3 Year strategy, embed in Fife by 2025.		Communication with senior nursing colleagues to ensure EIC is aligned to Care Assurance, SPSP, Documnetation and Fundamentals of Care work		Green - On Track
Increase NHS Fife Innovation Test Bed activity		Support Mental Health SBRI in Phase 2. Manage evaluation and moderation of Phase 2 applications of RDD Programme. Inform successful and unsuccessful applicants to Phase 2. Manage drafting and signing of contracts for successful applicants	9. Digital & Innovation	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Infection Prevention and Control support for Care Homes Continue to support Fife Care Homes to have a workforce with the necessary knowledge and skills in infection prevention and control to ensure they can practise safely, preventing and minimising the risks of HCAI to their residents, visitors, their co-workers and themselves.		Secure ongoing funding for the IPC Care Home Team- completed World Hand Hygiene Day Roadshow- completed Explore oppertunities for implementing IPC Link Practitioner Framework into care homes - in progress	8. Workforce	Green - On Track
Legal Services Department (LSD) role within the Board is to manage all clinical negligence, employers and public liability claims intimated against NHS Fife; Fatal Accident Inquiries in which NHS Fife is an involved and interested party and all other legal intimations and challenges which involve the organisation		Ongoing. Raise awareness of claims - similar claims and implement new procedures to avoid future claims		Green - On Track
Local Enhanced Services Review			1. Primary and Community Care	Green - On Track
Non-compliant Rotas		Recruitment and interviews complete, and candidates selected for Gateway EU Doctors joining August cohort. Revised medical rotas received final approval to go live for August cohort at 1A banding. Surgical rotas previously band 3 have had final approval to return to 1A banding for August cohort. Wellbeing & Engagement SLWG has drafted FAQ's, Induction information is currently being reviewed for use by SLWG.		Green - On Track
Pandemic Preparedness: Critical to major incident levels.		Guidance is awaited from Scottish Government for Pandemic preparedness. COVID -19 Public Enquiry module 1 recommendations were published on the 18 July 2024		Green - On Track
Rheumatology workforce model redesign			1. Primary and Community Care	Green - On Track
Scoping further areas to support Public Health/ NHS Fife priorities for evaluation and research.		Continue to scope areas which would benefit from research and evaluation support - includes Mental Health & Wellbeing in Primary Care and Communities Settings and Green Health Partnership	6. Health Inequalities	Green - On Track
Support for Doctoral Training Program (DTP) Fellows		Cohort 3 Fellows start 6 month lead in to August start date. Cohort 4 projects developed and submitted, joint proposal development meetings with University of St Andrews and NHS Fife.	8. Workforce	Green - On Track
To develop the resilience risk profiling for Emergency Planning for NHS Fife.		SLWG Held on 30 May with Key Stakeholders. Meeting held also with Director of Public Health (SRO) where agreement strategic risks go to PHAC and operational risks to RF.	2. Urgent and Unscheduled Care	Green - On Track
To support preparations within NHS Fife for the implementation of the HCSA Act (ongoing during 2023/24), which comes into force from 1 April 2024.		Review of SG HCSA feedback, submission of HCSA quarterly returns in line with agreed reporting mechanisms and governance cycles. Board actions progressed.	8. Workforce	Green - On Track
Translation and implementation of agreed Business case Options for Co-badged Clinical Trials Unit/Clinical Research Facility with University of St Andrews		Recommenced revisions to Template for submissions to VP Research, Innovations and Collections Principals Office. SBS briefing documents not received and progressing without.	6. Health Inequalities	Green - On Track
7 Day Pharmacy Provision. This will focus on provision of clinical and supply services across hospital care settings, reviewing the current position and additional need		Substantive weekend rota in place from July 2024.		Blue - Complete/ Target met
Ensure the delivery of an effective resilience function for NHS Fife.			6. Health Inequalities	Blue - Complete/ Target met

To Improve Staff Experience and Wellbeing

Deliverable	ADP Reference	2024/25 Q1 Comment	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Carers will have access to information where and when they want, that helps them to manage their caring role.	6.1	We will measure carers' perceptions of the support we offer and commission	6. Health Inequalities	**Amber - At risk - requires action**
Developing the skills of practitioners and professionals to identify and support carers at the earliest possible point in time	6.1		6. Health Inequalities	**Amber - At risk - requires action**
National - eRostering	9.1		9. Digital & Innovation	**Amber - At risk - requires action**
PPD Succession Planning		A new Head of PPD has been appointed and systems of working and training provision currently under review. Enhanced links with training and education providers are being established and training opportunities for B2-7 NMAHP staff are now being co-ordinated directly through the department.		**Amber - At risk - requires action**
Pre Registration Trainee Pharmacy Technicians (PTPT) The development of a pipeline of Pharmacy Technicians is crucial to the sustainability of Pharmacy services and in providing optimal care. Scottish Government funding for this pipeline was withdrawn in Autumn 2022, meaning a local solution is required to cover intakes from April 2023 onwards		Pharmacy SLT has discussed current risks with the pipeline following local and national developments. Due prioritisation of available resource considered		**Amber - At risk - requires action**
Develop an immunisation workforce model in conjunction with wider Primary Care Nursing structure which is sustainable and flexible to respond an ever evolving immunisation need	1.2		1. Primary and Community Care	**Green - On Track**
Improving support and developing the Mental Health workforce	3.5	Establish overarching MH Workforce Oversight group, update workforce profile; analysis of retention; attrition and vacancy profile	3. Mental Health	**Green - On Track**
Carers will have support to coordinate their caring role, including help to navigate the health and social care systems as they start their caring role.	6.1	Support skills development of social work assistants by delivering training courses - EPIC and Good Conversations.	6. Health Inequalities	**Green - On Track**
Ensuring young carers in Fife feel they have the right support at the right time in the right place to balance their life as a child/teenager alongside their caring role	6.1		6. Health Inequalities	**Green - On Track**
We will help carers to take a break from caring when, where and how they want to, so they are rested and able to continue in their caring role	6.1		6. Health Inequalities	**Green - On Track**
Delivering Anchor Institution workforce aims - Promoting employability priorities	6.4	Other programme aims for 2023/24 and 2024/25 identified and progressed in line with Workforce Planning priorities. Development of Employability Action Plan in line with Anchor ambitions, ADP and Workforce Planning priorities.	6. Health Inequalities	**Green - On Track**

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Develop a Health Visiting workforce model in alignment to the wider Primary Care Nursing with a focus on sustainable and flexible responses to agreed Health Visiting pathways and prioritisation for vulnerable families.	7.1	Analyse on an ongoing basis the existing staffing model to ensure HV pathway delivered. Recruit and support adequate HV trainees to ensure adequate staffing.	7. Women & Children Health	Green - On Track
Delivery of Staff Health & Wellbeing Framework aims for 2023 to 2025	8.3	Agreed evaluation and metrics in place for measuring outputs of staff health & wellbeing activities, including sustained reduction in absence levels, initially targeting 6.5% in 2024/25. Implementation of Staff Health & Wellbeing Action Plan for 22/25.	8. Workforce	Green - On Track
Development and implementation of the NHS Fife Workforce Plan for 2022-2025	8.5	Monitoring output of RTP programmes reviewing current and future composition of workforce, including provision of workforce data detailing growth trends and proposing future contractions. Review of RiWW mitigations linked to workforce challenges and / or cost pressures, in addition to impact of Band 5 nursing review and protected learning time. Integration of Common Staffing Method tool runs, and the Health Care Staffing Act, into wider workforce planning considerations with regards safe staffing levels and review of regular and recurring risks. Alignment of programmes with the Service Level Workforce Plans, in preparation for 2025 Workforce Plan Publication.	8. Workforce	Green - On Track
Delivery of the eRostering Implementation Programme in conjunction with Digital & Information.		BAU Team recruitment underway.	8. Workforce	Green - On Track
Development of workforce planning for Pharmacy and Medicines, including readiness for pharmacist graduate prescribers from 2026, education and training of staff groups and development of the Pharmacy Technician pipeline.		Increased DPP numbers delivered Revised end of placement meetings in place for 3rd year EL Pharmacy Students Revised rotational programme agreed for PGFTPs Pharmacists identified for post graduate research and clinical modules (linked to advanced practice) - notes of interest have been sought locally IP Legacy staff commence course (this happens every quarter)	8. Workforce	Green - On Track
Education reform for Pharmacy -Facilitate local implementation and delivery of revised NES programmes, and more broadly support the development of Pharmacy staff to deliver a modern, patient focussed pharmacy service, across NHS Fife. -Foundation training programmes and embedding the advanced practice framework for Pharmacists -Developing Pharmacy and Support workers through accredited courses and modules. -Collaborative working across the East Region to support simulation training for post graduate foundation trainees -Support for undergraduate experiential learning is also being developed to enhance the quality of education at that level -Work is also ongoing to develop clinical skills and leadership across all roles and increase research capability across the professions		Existing pre-reg cohorts completed Further staff have completed simulation training, increasing the clinical capability within the team. NRAC allocation has been offered, with the majority of places taken for 2024/25 (71/79)		Green - On Track
Medical Workforce Recruitment and Retention Strategic Framework		Scoping of the Framework		Green - On Track
Progression with ScotCOM in collaboration with the University of St Andrews		51 students have self selected to start ScotCOM with the GMC giving support for the programme to progress towards delivery		Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
We will launch and develop a leadership framework – Our Leadership Way in Fife.		In June, launch the concept of Our Leadership Way with the Systems Leadership Group to establish early perspectives on a shared leadership philosophy that sets the foundations for what Fife believes is the kind of leadership essential for fostering a thriving and sustainable future. Establish a collaborative volunteer group to shape the efforts to embed NHS Fife's leadership framework.	8. Workforce	Green - On Track

To Deliver Value & Sustainability

Deliverable	ADP Reference	2024/25 Q1 Comment	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Business Transformation		Savings being delivered through Digital opportunities. However, limited assurance remains due to delays in the programme commencing.		9. Digital & Innovation	Red - Unlikely to complete on time/meet target
Delivery of New Laboratory Information system (LIMS) as part of accelerated implementation followed by implementation of national roll out.	9.1	Complete local implementation and secure revised timeline for national build. Likely to be Q4 2024/25.	Implementation of national product	9. Digital & Innovation	Red - Unlikely to complete on time/meet target
Hospital Pharmacy Redesign Introduction of automation in hospital Pharmacy stores, dispensaries and clinical areas. Centralisation of Pharmacy stores.		Funding not available for large scale programme currently. Work to centralise procurement team and routes at VHK underway. Links established with RTP infrastructure programme.			Red - Unlikely to complete on time/meet target
SLA and External Activity		Ongoing discussions with NHS Lothian on financial planning assumptions and the implications of the introduction of PLICS. NHS Fife have engaged with Scottish Government and plan to implement PLICS locally by December 2024. Ongoing discussion with NHS Tayside on financial planning assumptions. Deep dive commenced into referral volumes by locality and specialty. Clinical leads fully engaged in this review and proposals for repatriation of a small number of services in development.	Extrapolation of data on outpatient activity in other boards complete Initial and subsequent deep dive of data Discussions with clinical leads and directors Draft Performance Management group TOR developed		Red - Unlikely to complete on time/meet target
Surge Capacity - Improve flow within the VHK site, reducing length of stay and number of patients boarding to ensure patients are looked after in the most appropriate setting. Accurate PDD to inform planning for discharge, coordinated with the Discharge Hub.	2.5	Acute are operating at winter-level pressures continuously. Despite this, occupancy below expected target levels and progress remains positive. If investment is not available to recruit to substantive nursing and consultant posts to manage surge beds, then this scheme will not achieve the savings outlined. Timeline slippage for move from Ward 10 to Ward 6 due to completion of works and cleaning dates.	Length of stay meetings continue. Overall surge is reduced. Improved discharge planning, fully utilising an MDT approach and PDDs. Implementation of ward access targets.	2. Urgent and Unscheduled Care	Red - Unlikely to complete on time/meet target

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Develop Strategic vision across all of Primary Care	1.2	Establish revised implementation of the non-priority MoU2 services within the current allocated resource. Work with LMC and GP-Sub to reach mutual agreement of the revision. Create an environment to progress the agreed changes and commence roll out.	1. Primary and Community Care	Amber - At risk - requires action
Maximise models of care and pathways to prevent presentations and support more timely discharges from ED using a targeted MDT approach	2.4	ED redirection rates continue to improve at 78%. SLWG established to review MIUs across Fife with Partnership colleagues.	2. Urgent and Unscheduled Care	Amber - At risk - requires action
Increase mental health services spend to 10% of NHS frontline spend by 2026 and plans to increase the spend on the mental health of children and young people to 1%	3.4		3. Mental Health	Amber - At risk - requires action
Roll out of Digital Pathology	5.1	Complete staff training Integration of digital systems with LIMS/Labcentre (Citadel)	5. Cancer Care	Amber - At risk - requires action
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation	8.1	Considering redeployment to support the transition into a staff bank from existing system cost pressures	8. Workforce	Amber - At risk - requires action

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
National - GP IT Reprovisioning - GP Sustainability	9.1		9. Digital & Innovation	Amber - At risk - requires action
National - LIMS Implementation	9.1		9. Digital & Innovation	Amber - At risk - requires action
Delivery of digital medicines programme, including the roll out of HEPMA and progressing commitments to implement automation within the hospital dispensary function		Med rec and IDL system - awaiting on change controls to be built and implemented Stock control system - begun build process and currently undergoing training of super-users HEPMA - cannot start install until stock control complete, background work ongoing	9. Digital & Innovation	Amber - At risk - requires action
Develop and Implement the Corporate Communication Strategy		Corporate Communications Strategy and Framework to be updated to reflect RTP Framework requirements		Amber - At risk - requires action
Develop and Implement the Public Participation and Community Engagement Strategy		Community Engagement and Public Participation Strategy presented at Board meeting in May		Amber - At risk - requires action
Enhanced data availability and sharing			9. Digital & Innovation	Amber - At risk - requires action
Procurement Savings within Acute Services		Implementation plan in place and a range of projects underway.		Amber - At risk - requires action
Set out approach to develop and begin implementation of a building energy transition programme to deliver energy efficiency improvements, increase on-site generation of renewable electricity and decarbonise heat sources.			10. Climate	Amber - At risk - requires action
Support delivery of Re-form, Transform, Perform (RTP) through supporting service change		RTP framework developed supported by Corporate PMO. A number of 3% schemes are being supported by the PMO. Corporate PMO currently supported development of portfolio management structure for RTP.		Amber - At risk - requires action
Improve sustainability of Primary Care	1.1	Create detailed view of sustainability across General Practice	1. Primary and Community Care	Green - On Track
Develop plans to make sure CIS delivers on key operational priorities	1.2		1. Primary and Community Care	Green - On Track
Developing a system wide Prevention and Early intervention strategy which will underpin delivery of the HSCP strategic plan and the NHS Fife Population Health and Wellbeing Strategy	1.4		1. Primary and Community Care	Green - On Track
Implement Same Day Emergency Care (SDEC) and rapid assessment pathways	2.2	Expansion of ECAS out of hours Increase to 7-day service OPAT Redeployment options for Ward 53 and ANPs. Skill mix being reviewed and safer staffing matrix completed.	2. Urgent and Unscheduled Care	Green - On Track
Mental Health Services will have a robust data gathering and analysis system to allow for service planning and development	3.3	Individual service KPI development commenced	3. Mental Health	Green - On Track
To achieve additional capacity to meet 6 week target for access to 3 key Radiology diagnostic tests (MR,CT and US)	5.2	Review of DCAQ , capacity GAPS identified and 24/25 recovery plan submitted to SG. Financial investment for additional activity received May 2024 and planning commenced to achieve additional activity projections. Additional CWT funding secured to support additional activity to maintain 2 week wait for all USOC and U referrals. Focussed work continues on acquisition to report turnaround times to optimise cancer pathways. Dedicated RCDS funding will enable sustained diagnostic waiting times for this service Engagement in RTP reimagining VHK site programme to ensure Radiology resource is sufficient to meet demands for in-patient and unscheduled care imaging as these services are redesigned.	5. Cancer Care	Green - On Track
Refreshed Performance Reporting	6.1		6. Health Inequalities	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Delivery of integrated drug and alcohol education age and stage appropriate throughout the full school life by school-based staff and specialist support from ADP commissioned services	6.2	Project Board to identify test schools and their training needs based on staff and student feedback via School Wellbeing survey Identify staff most appropriate to deliver training Devise Training content for school staff Commence training during twilight sessions pre and post evaluations conducted Staff in school (PSE and guidance teachers) to deliver sessions to students following lesson plan provided by third sector service	6. Health Inequalities	Green - On Track
Delivery of ICO and NISD Audit Improvement Plans Architecture and Resilience Developments	9.2	ICO Audit Action Plan Agreed Resilience Framework Established	9. Digital & Innovation	Green - On Track
Local - Records Management Plan Implementation	9.2		9. Digital & Innovation	Green - On Track
Infrastructure - RTP	9.31	Development of Asset Management Approach Implement approach	9. Digital & Innovation	Green - On Track
Infrastructure - Workforce	9.31	Provision Lynebank Decommission Hayfield	9. Digital & Innovation	Green - On Track
Digital Enablement Workplan for patients and staff ITIL 4 Improvement	9.4	Training Concludes	9. Digital & Innovation	Green - On Track
Development and initiation of NHS Fife Innovation Project Review Group (IPRG)	9.5	Develop membership of IPRG and initiate meeting on a bi-monthly basis.	9. Digital & Innovation	Green - On Track
Set out our approach to adapting to the impacts of climate change and enhancing the resilience of our healthcare assets and services	10.2		10. Climate	Green - On Track
Achievement of Waste Targets as set out in DL (2021) 38	10.3		10. Climate	Green - On Track
Decarbonisation of Fleet in line with Targets	10.41		10. Climate	Green - On Track
Action plan for the National Green Theatres Programme			10. Climate	Green - On Track
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Recruitment Shared Services Implementation Consolidation & enhanced International Recruitment service		International recruitment campaign closed appointing 104 international staff to both nursing and radiology.	8. Workforce	Green - On Track
Complete NHS Fife's Phase 2 M365 Programme		Establish a secure baseline in the M365 products and national tenancy	9. Digital & Innovation	Green - On Track
Development of a delivery plan to embed and deliver the Realistic Medicine Programme in NHS Fife		To develop Realistic Prescribing guidelines for chronic disease management and frailty		Green - On Track
Enhance the capacity and capability across the team		Review of authorisation limits complete and approved at EDG. Team engaging with RTP framework as reported at the Procurement Governance Board in July 2024. Management continue to support and lead team on learning programme to increase procurement knowledge and expertise.		Green - On Track
Estates Rationalisation		Hayfield House closed. Agile solutions in place at Queen Margaret, Lynebank, VHK staff club (St Andrews and Adamson Hospital to follow shortly).		Green - On Track
Further developing agile working and use of digital solutions in Directorate through investment in Workforce Analytics provision to support series of org. priorities, including Health and Care Staffing Act and eRostering Programme.		Continued creation of on line Workforce information overview accessible within NHS Fife. Review of Workforce Analytics as part of Directorate service change proposals implemented. Ongoing production of workforce information to support workforce planning and service delivery, including safe staffing reporting requirements.	8. Workforce	Green - On Track

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Further strengthen our business partnering model, supported by a strong management accounting team, to improve business performance and decision making support.		Further developed monthly reporting to capture delivery of financial savings targets and informed year end forecast position. Ensured learning from the national Financial Improvement Network is cascaded across the finance team and stakeholders as appropriate. Strengthened even further stakeholders' grip and control responsibilities to underpin delivery of our financial targets and, in turn, supporting the delivery of our Reform, Transform and Perform programme. Continuously review mandatory training requirements and ensure team statistics are maintained within the 'green' tolerance range.		Green - On Track
Implementation of environmental prescribing improvements per the Scottish Government Quality Prescribing for Respiratory guide 2024			10. Climate	Green - On Track
Increase capability within the team to deliver service improvement and meet growing service demand		Imbed revised interface to support processing of agency invoices, providing enhanced oversight and control. New Processes for Direct engagement imbedded.		Green - On Track
IPQR Review		Review of trajectories/targets Incorporate initial metrics relating to Mental Health Produce redesigned report for EDG (Jun-24) for distribution to Committees and Board (Jul-24)		Green - On Track
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets		Production of comprehensive communications plan to enhance optimisations work on all sides, involving a wide range of stakeholders including patients and clinicians, including medicines waste. Significant design and delivery work undertaken, including of targets and identification of staffing resource. Medicines waste campaign being developed, including updated materials	6. Health Inequalities	Green - On Track
Outline plans to implement an approved Environmental Management System.			10. Climate	Green - On Track
Outline plans to implement a sustainable travel approach for business, commuter, patient and visitor travel			10. Climate	Green - On Track
Outline plans to increase biodiversity and improve greenspace across our estate			10. Climate	Green - On Track
Post successful transition to the SE Payroll Consortium arrangement, work with the senior leadership of the consortium to ensure effective continuity of a payroll service for NHS Fife and contribute to service redesign to ensure NHS Fife's needs are addressed.		Draft SLA developed and circulated to consortium members for approval		Green - On Track
Reduction of Medical Gas Emissions through implementation of national guidance			10. Climate	Green - On Track
Support Delivery Strategic Planning function		Organise Winter Review even (cancelled, not to be rescheduled) Develop process for quarterly monitoring of ADP25/25		Green - On Track
Transfer our referral system and EPR from Tiara to Morse and TrakCare within the Podiatry service			1. Primary and Community Care	Green - On Track
Transformation of HR transactional activity enhancing the HR Operational delivery model through case management and manager support building on manager/employee self-service		New model of service delivery in transition, new SOP's being developed and creation of new posts and systems development work.	8. Workforce	Green - On Track
Refresh of the Primary Care Improvement Plan	1.1	Where applicable, align staff to new combined roles, supporting Immunisation and CTAC/Immunisation Service.	1. Primary and Community Care	Blue - Complete/ Target met

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Review existing arrangements which support children with neurodevelopmental differences.		Consider, and where appropriate, develop different models of support which are person centred providing the right care in the right place at the right time by the right person "Finalise new multi-agency pathway. Implement new models of support and associated outcomes measures."	7. Women & Children Health	**Blue - Complete/ Target met**

ALL

Deliverable	ADP Reference	2024/25 Q1 Comment	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status

Deliverable	ADP Reference	2024/25 Q1 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status
Develop the NHS Fife Organisational Change Model to support delivery of change.		Commenced scoping of this work.		Green - On Track
Supporting implementation of the Population Health & Wellbeing Strategy		Complete the 2023-24 Annual Report and signed off at the May 2024 Board Meeting		Green - On Track

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Scottish Healthcare Associated Infection Strategy 2023-25 Update**
Responsible Executive:	**Janette Keenan, Director of Nursing, HAI Executive Lead**
Report Author:	**Julia Cook, Infection Control Manager**

Executive Summary:

- The intention of the two-year HCAI Strategy is to establish a new baseline position which will provide the foundations for a five-year IPC strategy which will follow (2025-2030).

- **Year 1** was dedicated to the ongoing review of existing guidance, processes, and educational materials. The responsible stakeholders for these deliverables:
    - the Scottish Government
    - National Health Boards (ARHAI Scotland, NHS Scotland Assure and NES).

- **Year 2** will focus on planning, implementing, and embedding the outputs of year one. The Scottish Government expect that year two may include specific deliverables for Territorial Health Boards. The Scottish Government will communicate this as appropriate and will engage with stakeholders on the details of year two which will inform an updated delivery plan.

- Understanding the outcomes of year 1 actions is crucial for local Health Boards to determine the next steps and tailor their strategies for implementation at the local level.

- Health Board representatives have been invited to the ARHAI Scotland Gram-Negative Bacteraemia Stakeholder Session on Thursday 19 September 2024. Following this event NHS Fife IPC Team will take a number of actions as highlighted in the main body of report.

- The Report is for assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- NHS Board Strategic Priorities:
    - To Improve Health & Wellbeing
    - To Improve Quality of Health & Care Services

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is to provide assurance and an update to the Clinical Governance Committee on the Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025.

2.2 Background

HCAIs result in longer hospital stays, increased healthcare costs, and additional overall pressures on health and social care resources. the Scottish HCAI Strategy 2023 – 2025, aims to play an essential role in improving the quality of care we provide, enhancing the overall health of our communities.

Previous HCAI strategies followed a five-year running period to allow for adequate transformation to take place. This current strategy only covers the interim period of 2023-2025. The intention of this two-year HCAI Strategy is to establish a new baseline position which will provide the foundations for a five-year IPC strategy which will follow (2025-2030).

The strategy highlights the importance of ongoing education and training, surveillance, and monitoring. The 7 strategic goals are developed based on the WHO Infection Prevention and Control (IPC) Core Components. The overarching aim is to reduce HCAI incidence and aid in the recovery from COVID-19.

Year 1

Year 1 was dedicated to the ongoing review of existing guidance, processes, and educational materials. The responsible stakeholders for these deliverables are primarily the Scottish Government and the National Health Boards (ARHAI Scotland, NHS Scotland Assure and NES).

Year 2

Whilst the review of guidance, process and educational materials will continue, year two will focus on planning, implementing, and embedding the outputs of year one. The Scottish Government expect that year two may include specific deliverables for Territorial Health Boards.

The Scottish Government will communicate this as appropriate and will engage with stakeholders on the details of year two which will inform an updated delivery plan.

2.3 Assessment

Health Boards are currently awaiting outcomes of year 1 actions which were focused on national bodies as per the Scottish HCAI Strategy 2023 - 2025.

Understanding the outcomes of year 1 actions is crucial for local Health Boards to determine the next steps and tailor their strategies for implementation at the local level.

Health Board representatives have been invited to the ARHAI Scotland Gram-Negative Bacteraemia Stakeholder Session on Thursday 19 September 2024. Following this event NHS Fife IPC Team shall:

- Convene a meeting(s) to discuss the forthcoming outcomes of year 1 actions and strategise for the implementation phase in year 2.
- Collaborate with relevant stakeholders to ensure a coordinated approach in aligning local initiatives with the national strategy.
- Provide bimonthly updates to the Infection Prevention and Control Committee.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

The infection prevention and control team is essential to the delivery of high quality patient care and to the provision of a clean and safe environment for patients, visitors and other service users. The Local Integrated Service Delivery Infection Control Strategic Workforce Plan (LISDP) is being developed and implemented.

2.3.3 Financial

Financial pressures are unknown currently whilst year 1 outcomes are awaited.

2.3.4 Risk Assessment / Management

Actions currently with national bodies. A full risk assessment shall be undertaken once further communications and directives are received from Scottish Government.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

The Scottish HCAI Strategy 2023- 2025 details following an Equality Impact Assessments (EQIAs) screening exercise, it was found that people of protected characteristics as outlined in the Equality Act (2010) are not impacted either positively or negatively by this strategy. Therefore, an EQIA was not required in this instance.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager and HAI-Executive

2.3.8 Route to the Meeting

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

- Executive Directors' Group, 15 August 2024

2.4 Recommendation

This paper is provided to members for a **"significant"** level of assurance.

3 List of appendices

Appendix 1 – HCAI Strategy 2023 – 2025 – can be found at this link: Healthcare Associated Infection (HCAI) strategy 2023 to 2025 - gov.scot (www.gov.scot)

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

Executive Summary

There are 15 metrics reported to Clinical Governance Committee via the IPQR, of which, 6 (relating to Adverse Events, HSMR & Mental Health Incidents) have no defined trajectory/target.

- For all 12 metrics that have SPC methodology applied, current position is “within control limits”.

This report provides Moderate Level of Assurance.

1 Purpose

This report is presented for:
- Assurance

This report relates to:
- Annual Delivery Plan

This report aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred
- NHS Board Strategic Priorities:
  - To Improve Health & Wellbeing
  - To Improve Quality of Health & Care Services
  - To Improve Staff Experience & Wellbeing
  - To Deliver Value & Sustainability

2 Report summary

2.1 Situation

This report informs the Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key health and wellbeing measures (as defined by Scottish Government 'Standards' and local targets).

The period covered by the performance data is generally up to the end of June 2024, although there are some measures with a significant time lag and two which are available up to the end of July 2024.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board and is produced monthly. Each Governance Committee will receive separate extracts of the IPQR to scrutinise the performance areas relevant to each Committee. Reports which are not prepared for Governance Committees are data only and contain neither data analysis nor service commentary.

NHS Fife were required to provide trajectories for a range of metrics as part of ADP process for 2024/25. This requirement was extended to all metrics included within IPQR with trajectories agreed with Services up to Mar-25. The IPQR will monitor achievement against 2024/25 trajectories and Mar-25 target. For this Committee, this only applies to Stage 2 Complaints.

A summary of the Corporate Risks has been included in this report. Risks are aligned to Strategic Priorities with risk level incorporated into the Assessment section.

Statistical Process Control (SPC) charts continue to be used for applicable indicators.

2.3 Assessment

The IPQR provides a full description of the performance, achievements and challenges relating to key measures in the report.

New measures included this month and onwards are related to Public Health Screening and Child Health with work to continue throughout 2024/25 in relation to inclusion of Primary Care and Public Health (including Climate Emergency) metrics:

Public Health & Wellbeing

- Breast and Bowel Screening
- Abdominal Aortic Aneurysm (AAA) Screening
- Infant Feeding
- Child Developmental Concerns

Highlights of July 2024 IPQR

A summary of the status of the Clinical Governance metrics is shown in the table below.

Measure	Current Position	Reporting Period	Planned Trajectory	Target
Adverse Events	38	Jun-24	-	-
Actions Closed (LAER/SAER) [1]	37.8%	Mar-24	-	50%
HSMR	0.96	Dec-24	-	-
Falls	7.38	Jun-24	-	6.95
Falls with Harm	1.63	Jun-24	-	1.44
Pressure Ulcers	1.24	Jun-24	-	0.89
Ligature Incidents (MH)	0.71	Jun-24	-	-
Incidents of Restraint (MH)	10.70	Jun-24	-	-
Incidents of Physical Violence (MH)	13.55	Jun-24	-	-
Incidents of Self Harm (MH)	0.89	Jun-24	-	-
SAB (HAI/HCAI)	28.0	Jun-24	-	18.8
C Diff (HAI/HCAI)	7.0	Jun-24	-	6.5
ECB (HAI/HCAI)	59.6	Jun-24	-	33.0
Complaints (S1)	59.5%	Jul-24	-	80%
Complaints (S2)	20.5%	Jul-24	50%	60%

[1] Performance reporting for Actions Closed (LAER/SAER) was previously a 1-month lag but has moved to 3-month lag.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

Financial reporting is covered in the specific section of the IPQR.

2.3.4 Risk Assessment / Management

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

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

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

The Clinical Governance extract of the Position at July IPQR has been made available for discussion at the meeting on 06 September 2024.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 15 August 2024 and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

This paper is also provided for **discussion** - for examining and considering the implications of the matter.

3 List of appendices

- Appendix 1 - IPQR Position at July 2024

Report Contact
Bryan Archibald
Planning and Performance Manager
Email bryan.archibald@nhs.scot

Fife Integrated Performance & Quality Report (IPQR)

Position (where applicable) at July 2024
Produced in August 2024

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

The IPQR comprises the following sections:

A. Corporate Risk Summary
Summarising key Corporate Risks and status.

B. Indicatory Summary
Summarising performance against full list of National Standards and local KPI's. These are listed showing current performance against target/trajectories with comparison with 'previous' performance.

C. Assessment & Performance Exception Reports
More detailed Indicator Summary for each area of Governance including (where appropriate) benchmarking, 'sparkline' trend, comparison with 'previous year' performance. There is also a column indicating performance 'special cause variation' based on SPC methodology. Also incorporated into this section is an assessment for indicators of continual focus or concern. Content includes data analysis, service narrative and additional data presented in charts, incorporating SPC methodology, where applicable. Performance RAG is based on, if applicable, agreed trajectories for 2024/25, otherwise against National/Local target. All charts with SPC applied will be formatted consistently based on the following; 24-month Average ----- Control Limit ● Outlier

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

C1. Quality & Care	C2. Operational Performance & Finance	C3. Workforce	C4. Public Health & Wellbeing

MARGO MCGURK
Director of Finance & Strategy
13 August 2024

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

A. Corporate Risk Summary

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◀▶	High
To improve the quality of health and care services	6	4	2	-	-	◀▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀▶	Moderate
To deliver value and sustainability	7	5	2	-	-	◀▶	Moderate
Total	**19**	**13**	**6**	**0**	**0**		

Risk Key

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

Movement Key

- ▲ Improved - Risk Decreas
- ◀▶ No Change
- ▼ Deteriorated - Risk Incre

Summary Statement on Risk Profile

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

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

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

B. Indicator Summary

Quality & Care

Indicator	Current	Previous	Change
LAER/SAER % Actions Closed on Time	37.8%	52.2%	▼
Ligature Incidents (Mental Health)	0.71	0.33	▼
Incidents of Self Harm (Mental Health)	0.89	0.82	▼
ECB HAI	59.6	46.7	▼
Inpatient Falls	7.38	7.44	◆
Incidents of Restraint (Mental Health)	10.7	12.0	▲
SAB HAI	28.0	16.7	▼
S1 Complaints Closed in Month on Time	59.5%	68.9%	▼
Pressure Ulcers	1.24	1.52	▲
Incidents of Physical Violence (Mental Health)	13.55	10.22	▼
C Diff HAI	7.0	6.7	◆
S2 Complaints Closed in Month on Time	20.5%	21.4%	▼

Operational Performance

Indicator	Measure	Current	Previous	Change
Emergency Access	A&E	75.3%	74.4%	▲
Emergency Access	ED	68.2%	66.4%	▲
Patient TTG	% <=12weeks	45.4%	47.1%	▼
Patient TTG	>52 weeks	642	642	◆
Delayed Discharges (Standard)	Acute/Comm	46	55	▲
Delayed Discharges (Standard)	MH/LD	7	9	▲
New Outpatients	% <=12weeks	41.6%	40.9%	▲
New Outpatients	>52 weeks	4970	4845	◆
Cancer	31-day DTT	95.0%	96.1%	▼
Cancer	62-Day RTT	71.1%	73.6%	▼
Diagnostics	% <=6weeks	62.8%	59.9%	▲
Diagnostics	>26 weeks	50	44	▼

Finance

Indicator	Current	Change
Revenue Resource Limit Performance	(£17.207m)	
Capital Resource Limit Performance	£1.274m	

Workforce

Indicator	Measure	Current	Previous	Change
Sickness Absence		7.17%	7.11%	◆
Personal Development Plan & Review		44.5%	43.5%	▲
Vacancies	Medical & Dental	6.2%	7.5%	▲
Vacancies	Nursing & Midwifery	3.8%	4.6%	▲
Vacancies	AHPs	3.7%	4.7%	▲

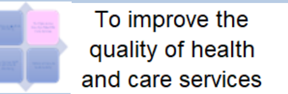
Public Health & Wellbeing

Indicator	Measure	Current	Previous	Change
Smoking Cessation	40% Most Deprived	285	255	▲
CAMHS		70.8%	86.0%	▼
Breast Screening		73.4%		—
Childhood Immunisation	6-in-1 @ 12 months	95.1%	94.9%	▲
Infant Feeding		31.6%	30.5%	▲
Alcohol Brief Interventions		120%	120%	◆
Psychological Therapies		67.8%	70.9%	▼
Bowel Screening		66.2%		—
Childhood Immunisation	MMR2 @ 5 years	85.7%	89.6%	▼
Child Development		18.4%	15.1%	▲
Mental Health Readmissions within 28 days		3.6%	2.4%	▼
Drugs & Alcohol		93.1%	83.8%	▲
AAA Screening		87.3%	86.8%	▲

Key

- ▲ Improved performance from previous month
- ◆ No significant change from previous month
- ▼ Reduction in performance from previous month

C1. Quality & Care



To improve the quality of health and care services	6	4	2	-	-	◀ ▶	Moderate

Indicator	Current Position	Reporting Period		Planned Trajectory	Target	SPC	Vs Previous	Vs Year Previous	Trend	Benchmarking	
Major/Extreme Adverse Events	38	Month	Jun-24			○	▲	▲		●	
LAER/SAER - % Actions Closed on Time	37.8%	Month	Mar-24		50%	●	▼	▼		●	
HSMR	0.96	Year to	Dec-23			●	—	—		●	
Inpatient Falls	7.38	Month	Jun-24		6.95	○	◆	▼		●	
Inpatient Falls with Harm	1.63	Month	Jun-24		1.44	○	▼	▼		●	
Pressure Ulcers	1.24	Month	Jun-24		0.89	○	▲	▼		●	
Ligature Incidents (Mental Health)	0.71	Month	Jun-24			○	▼	▼		●	
Incidents of Restraint (Mental Health)	10.70	Month	Jun-24			○	▲	▼		●	
Incidents of Physical Violence (Mental Health)	13.55	Month	Jun-24			○	▼	▼		●	
Incidents of Self Harm (Mental Health)	0.89	Month	Jun-24			○	▼	▼		●	
SAB - Healthcare associated infection	28.0	Month	Jun-24		18.8	○	▼	▼		●	YE Dec-23
C Diff - Healthcare associated infection	7.0	Month	Jun-24		6.5	○	▼	▲		●	YE Dec-23
ECB - Healthcare associated infection	59.6	Month	Jun-24		33.0	○	▼	▼		●	YE Dec-23
S1 Complaints Closed in Month on Time	59.5%	Month	Jul-24		80%	●	▼	▼		●	2022/23
S2 Complaints Closed in Month on Time	20.5%	Month	Jul-24	50%	60%	○	▼	▲		●	2022/23

Performance Key
- meeting trajectory/target
- within 5% of trajectory/target
- out with 5% of trajectory/target

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

Change Key
- ▲ "Better" than comparator period
- ◆ No Change
- ▼ "Worse" than comparator period

Benchmarking Key
- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile

LAER/SAER Actions Closed on Time

50% of LAER/SAER actions from Major and Extreme Adverse Events to be closed on time

37.8%

5 actions to be closed on time to achieve target

C1. Quality & Care

Data Analysis

Actions Closed (Reported to Mar-24)

There were 14 actions relating to LAER/SAER closed on time in Mar-24, from a total of 37, which equates to a performance of 37.8%: a decrease on the 52.2% the previous month (Feb-24) and less that the 48.8% seen the previous year (Mar-23).

There were 389 actions open at the end of Mar-24, with 82 (21.1%) being within time. On average, 56 actions have been closed per month in year to Mar-24 compared to 32 per month in the 12 months prior.

Adverse Events (Reported to Jun-24)

There were 38 Major/Extreme adverse events reported in Jun-24 out of a total of 1,466 incidents.

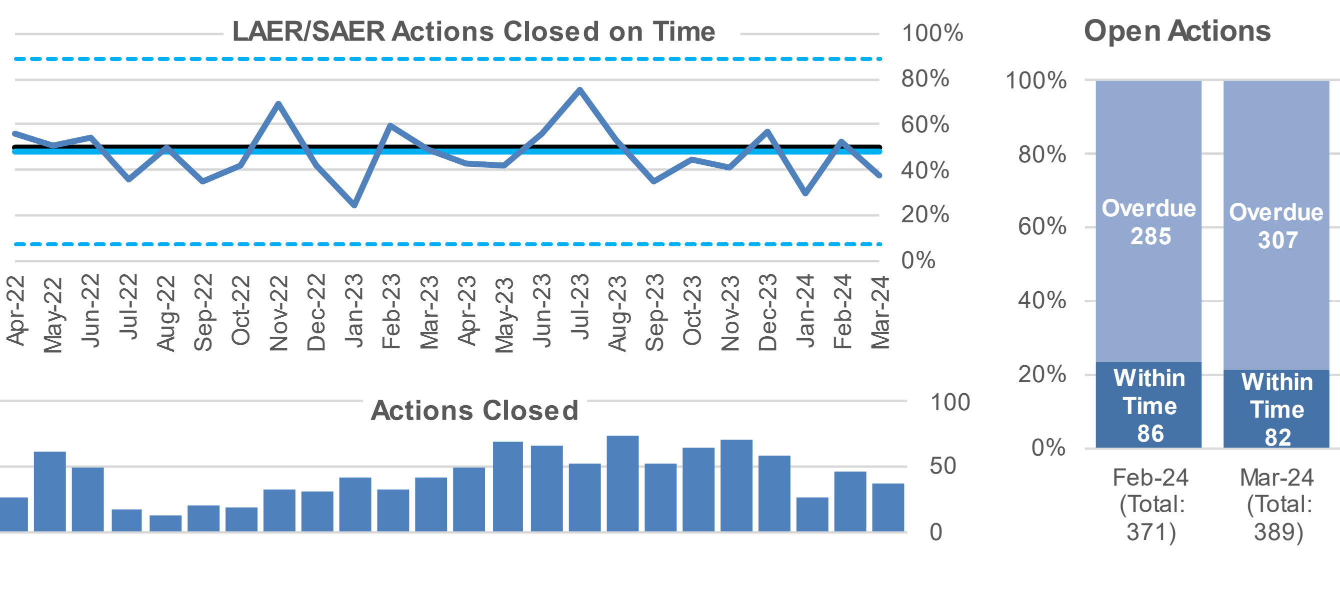
72% of all incidents were reported as 'no harm'. Over the past 12 months, 'Pressure Ulcer developing on ward' has been the most reported Major/Extreme incident (233) followed by 'Cardiac Arrest' (69 incidents), and then 'Other Clinical Events' (49 incidents).

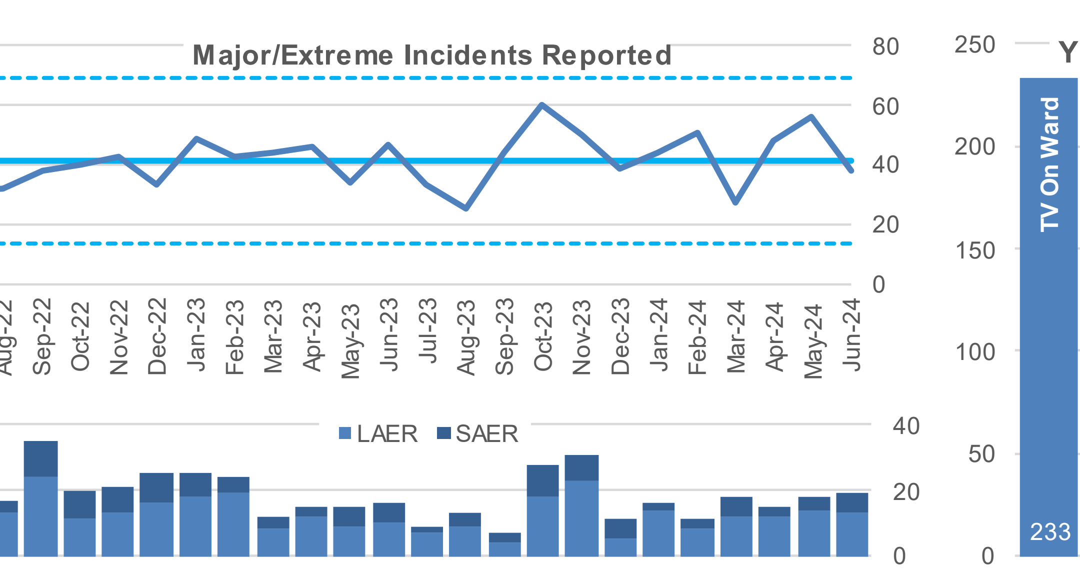
Achievements & Challenges

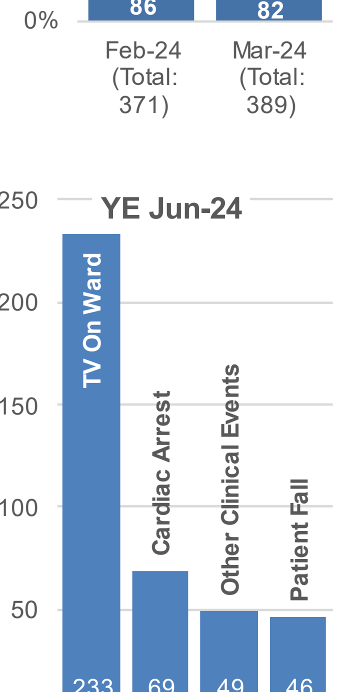
In June, Clinical Governance Oversight Group (CGOG) approved a refreshed approach to the Adverse Event trigger list which aligns with the HIS Framework. Managing the volume of SAERs is an ongoing challenge for clinical teams. It is anticipated that once embedded, the redefined trigger list will

- reduce the volume of SAERs
- initiate the development of systems, processes and governance to enable thematic learning and improvement planning in key areas, specifically falls and tissue viability
- ensure that there is a consistent approach to reporting levels of harm and commissioning the most appropriate type and level of review to enable learning.

Work continues to improve the compliance with the closure of actions on time. As part of this work, it has been agreed at CGOG that the improvement plans for all SAERs which have a review conclusion outcome 4 (preventable events) will be returned to the SAER Exec Panel for agreement and oversight.







Inpatient Falls

Objective	Current		
Reduce Inpatient Falls rate by 15% to 6.95 per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	7.38	12	falls to achieve target
Reduce Inpatient Falls with Harm rate by 10% to 1.44 per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	1.63	6	falls to achieve target

C1. Quality & Care

Data Analysis

The number of inpatient falls in total was 203 in Jun-24, 12 less than month prior but similar to March & April. This equates to a rate of 7.38 falls per 1,000 Occupied Bed Days (OBD). Performance therefore exceeds the target of < 6.95 but remains within control limits and is on par with the 24-month average.

Average rate was 7.35 for YE Jun-24 compared to 7.68 for YE Jun-23.

The number of inpatient Falls 'with Harm' was 45 in Jun-24, 6 more than the month prior. This equates to a rate of 1.63 falls per 1,000 OBD: thus, performance exceeds the target of < 1.44 but remains within control limits and is on par with the 24-month average.

Average total rate was 1.62 for YE Jun-24 which was the same for YE Jun-23.

In Jun-24, Acute Services saw a decrease in All Falls rate (21 fewer falls, rate of 6.92); whereas HSCP saw an increase in All Falls rate (9 more falls, rate of 7.79).

In the last 3 months - looking only at Falls with Harm - Falls classified as 'Minor Harm' accounted for 82%; 'Moderate Harm' accounted for 11%; and 'Major/Extreme Harm' accounted for 7% (same figures as reported QE Apr-24).

Achievements & Challenges

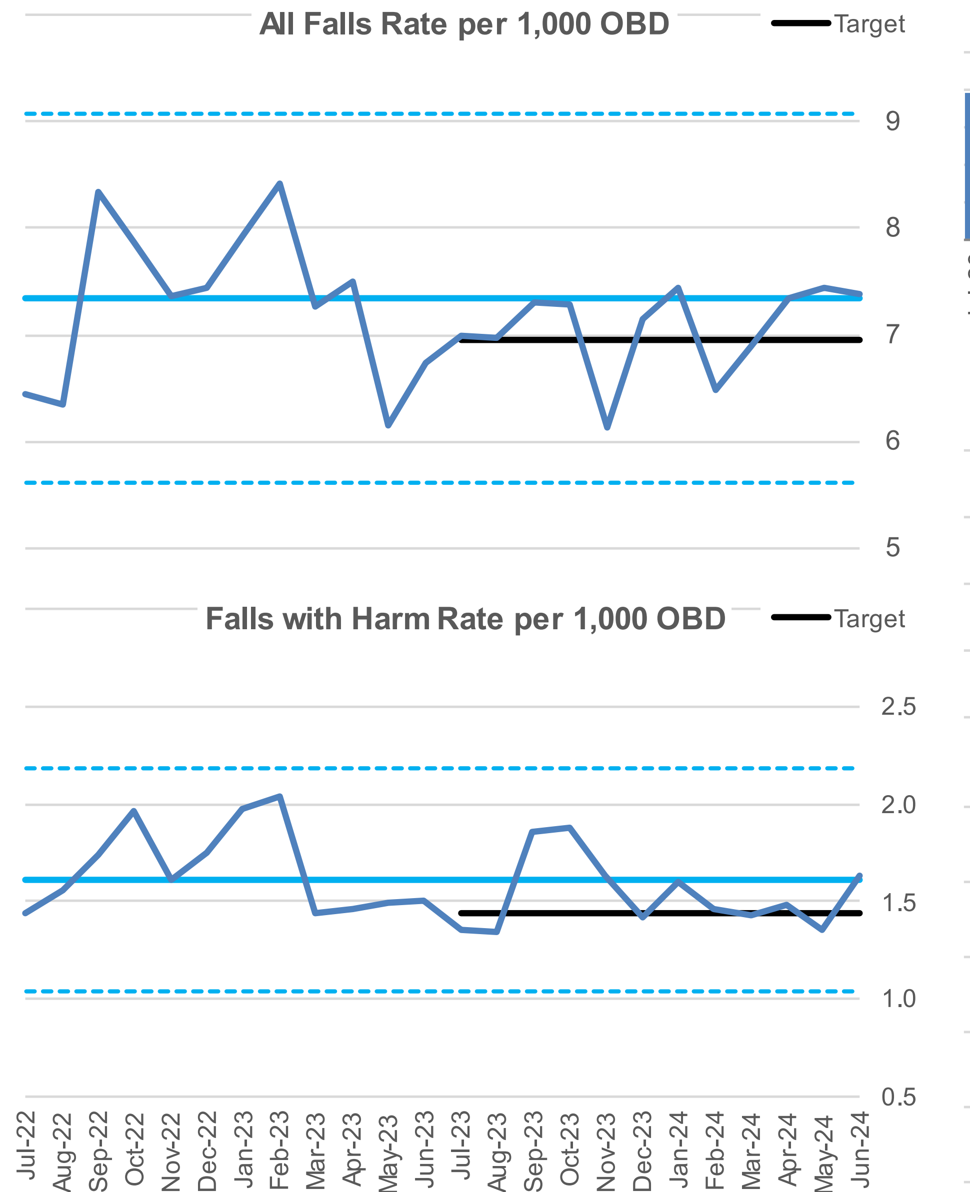
At the recent Safer Mobility & Falls Reduction Oversight Group meeting, it was noted that the Acute Falls group will be focussing on:

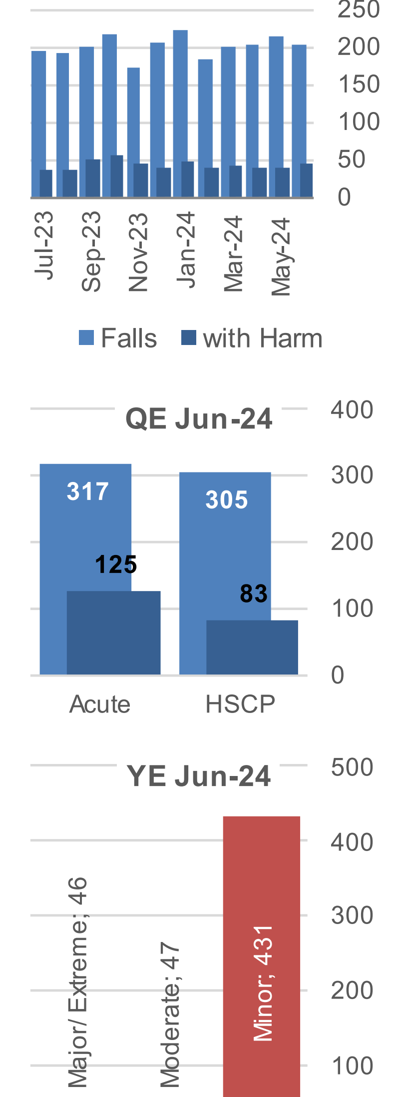
- Risk identification
- Preventative Intervention
- Staff Competency
- Interdisciplinary Collaboration
- Continuous Monitoring
- Patient Engagement

Work is ongoing to develop Link Practitioners.

HSCP update highlighted areas for improvement and have engaged with Clinical & Care Governance Team to support the improvement work required.

Discussion is underway regarding adopting the national framework for Adverse Events including definitions for major and moderate harms.





Pressure Ulcers

Reduce Pressure Ulcer rate by 20% to 0.89 per 1,000 Occupied Bed Days, compared to baseline rate (FY 2022/23)

1.24

10 pressure ulcers to achieve target

C1. Quality & Care

Data Analysis

The total number of pressure ulcers in Jun-24 was 34, which was 10 less than the month previous. This equates to a rate of 1.24 per 1,000 Occupied Bed Days (OBD). Performance therefore remains outwith the target of <0.89 per OBD and above the 24-month average though remains within control limits.

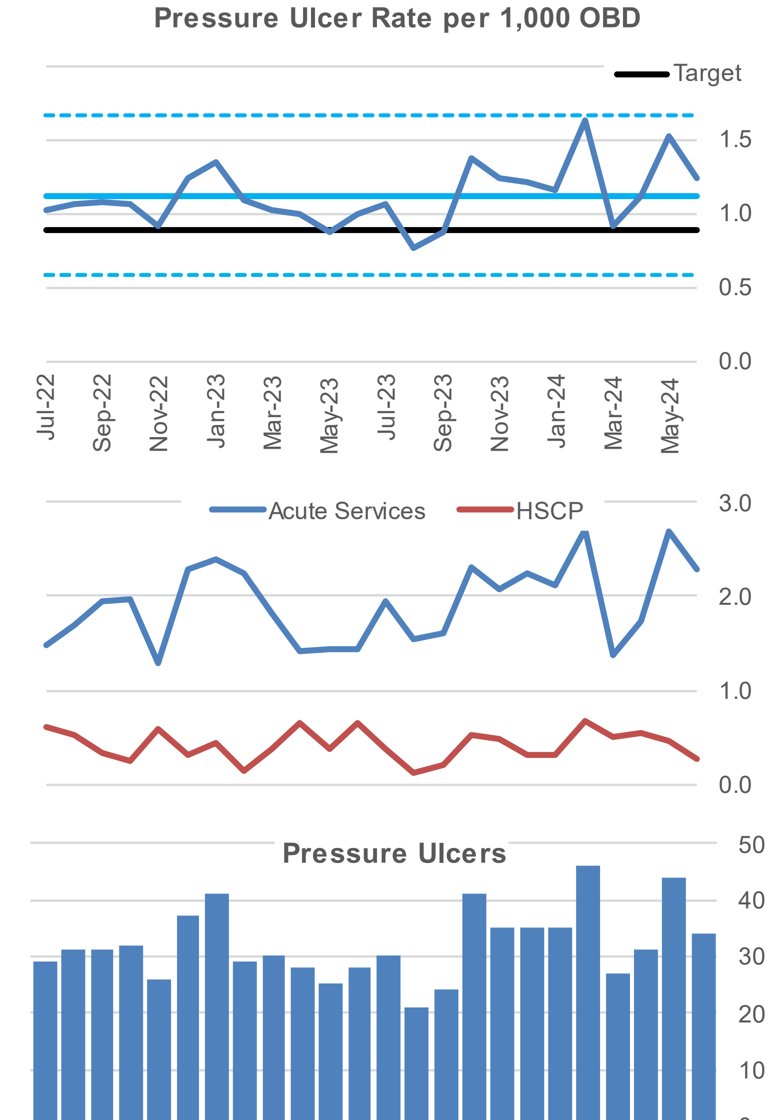
The number of pressure ulcers in Acute Services in Jun-24 was 30, 7 less than in May-24 (rate decreased from 2.69 to 2.28). For YE Jun-24, the average number of pressure ulcers was 28 (rate 2.06); whilst the average number in YE Jun-23 was 24 (rate 1.79).

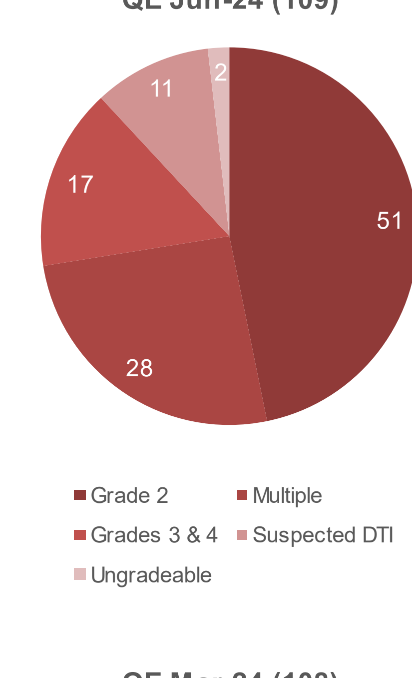
In HSCP, the average number of pressure ulcers for YE Jun-24 was 6 (rate 0.40); whilst the average number in YE Jun-23 was 7 (rate 0.44).

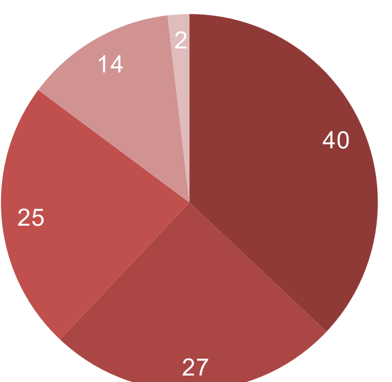
Most pressure ulcers continue to be in Acute Services with 90 recorded in QE Jun-24 compared with 19 in HSCP. Of all Pressure Ulcers recorded in QE Jun-24, Grade 2 accounted for 37% of the total; with Grades 3 & 4 accounting for 25%.

Achievements & Challenges

Acute Services face significant challenges in addressing on ward pressure damage, despite ongoing improvements. In June 2024, total number of pressure ulcers reduced to 34, with Acute Services reporting 30 cases: a decrease from May 2024. High severity levels persist, with Grade 2 ulcers accounting for 37% and Grades 3 & 4 making up 25% in QE June 2024. Efforts to address these issues include the joint Acute and HSCP Tissue Viability Improvement Group, which fosters collaborative strategies. Monthly meetings for link practitioners and ‘Ward of the Week’ initiative promote adherence to best practices and accountability. Ongoing education ensures staff are equipped with the latest prevention techniques. Regular service reviews help identify and implement necessary changes. Organisational learning will be trialled as part of a cluster review across Acute: incorporating input from the Tissue Viability Nurse (TVN) service, Heads of Nursing, and Quality & Risk teams. This collaborative approach aims to enhance prevention strategies and improve overall care quality. Within HSCP, the TVN team are providing targeted support to wards/clinical areas with higher incidence of pressure damage: the team are developing an education schedule which includes delivery to our care home colleagues. Our re-focused TV Improvement group has expanded representation to ensure acute colleagues are represented for collaborative learning and information sharing: the group is focused on the 7 standards from the SPSP Change package. We have also adopted a ‘cluster review’ approach to any TV related LAERs to ensure system-wide learning.







Mental Health Quality Indicators

Indicator	Value
Reduce **Ligature** Incidents (rate per 1,000 Occupied Bed Days)	**0.71**
Reduce incidents of **Self Harm** (rate per 1,000 Occupied Bed Days)	**0.89**
Reduce Incidents of **Restraint** (rate per 1,000 Occupied Bed Days)	**10.70**
Reduce Incidents of **Physical Violence** (rate per 1,000 Occupied Bed Days)	**13.55**

C1. Quality & Care

Data Analysis

There was 274 incidents reported in relation to Mental Health wards in Jun-24, a slight increase from 264 previous month but remains above 24-month average of 230 per month. There were four Ligature incidents reported in Jun-24, last 4 months below average after previous 7 months were above, with Feb-24 outwith control limits. The number of incidents of self-harm was 5 in Jun-24, same as month prior, fourth month in row below 24-month average.

Rate of Restraint has reduced from 24-month high of 15.6 per 1,000 Occupied Bed Days in Feb-24 to 10.7 in Jun-24, a reduction in incidents from 92 to 60. 76 incidents of Physical Violence were reported in Jun-24, an increase from 62 month prior, equating to a rate of 13.6 per 1,000 Occupied Bed Days, which is highest since 16.0 was reported in Sep-23.

Achievements & Challenges

Ongoing programme of work to the environment including the preparation of W3 QMH and the decant of 4 wards in rotation to upgrade the environment in each of them. Work within W3 QMH, has commenced but is not yet ready for accommodating patients. This work had been temporarily paused to allow for further consideration on clinical service design, which has been recommenced . Completion date for the whole project is expected to be at least 2 years.

The Ligature in patient mental health operational group is a working partnership between NHS Fife Health and Safety, Mental Health Management Team and NHS Fife Estates. The group exists to ensure that all H&S Environmental Ligature risk assessments are up to date with associated action plans to mitigate identified risk, as far as is reasonably practicable, and for the delivery of these action plans to be monitored and, where necessary escalated. There has been a Ligature Policy developed for NHS Fife and Fife HSCP with the final draft policy being shared widely for consultation. This policy and EQIA was discussed at the Fife Policy and Procedure Coordination and Authorisation Group and needs some minor changes before approval.

Within the in-patient ward areas, staff continue to be vigilant for any ligature concerns and manage patients individually according to their risk assessments and changes in their behaviours, management of patient risks would be through their care plans, and updated risk assessments to ensure safety plans are in place.

The number of self-harm except for tying ligatures is low, and there is currently no concentrated work on reducing self-harm. The ward staff continue to be vigilant for self-harm, awareness of patient's histories and behaviours with risks managed through their own individual care plans.

Work continues to reduce restrictive practice with monthly meetings of the Reducing Restrictive Practice Group (RRPG) to review progress. The initial stage of this work has concentrated on best practice for restraint, training and IM medication. The next stage, the group are moving on to is to implement Scottish Patient Safety Programme (SPSP) work including the creation of a driver diagram and consideration for small PDSA's and improvement work. This will involve work on Leadership and Culture, Safe Clinical Care, Safe Communications and Person-Centred care.

Work with HIS Improving Observation Practice has not continued and therefore there is a need to re-establish this workstream and align improvements to the policies. This has been acknowledged by the service, but work is yet to begin in this area.

Rate per 1000 Occupied Bed Days

Healthcare Associated Infections

CDI: Achieve and maintain rate of 6.5 per 100,000 Total Occupied Bed Days	**7.0**	1 ↓	infections to achieve target
ECB: Achieve and maintain rate of 33.0 per 100,000 Total Occupied Bed Days	**59.6**	8 ↓	infections to achieve target
SAB: Achieve and maintain rate of 18.8 per 100,000 Total Occupied Bed Days	**28.0**	3 ↓	infections to achieve target

C1. Quality & Care

The **CDI HAI/HCAI** rate increased to 7.0 in Jun-24. The cumulative total of HCAI infections for past 12 months (n=18) is significantly lower than the same period previous year (n=44), The number of recurring infections has also decreased.

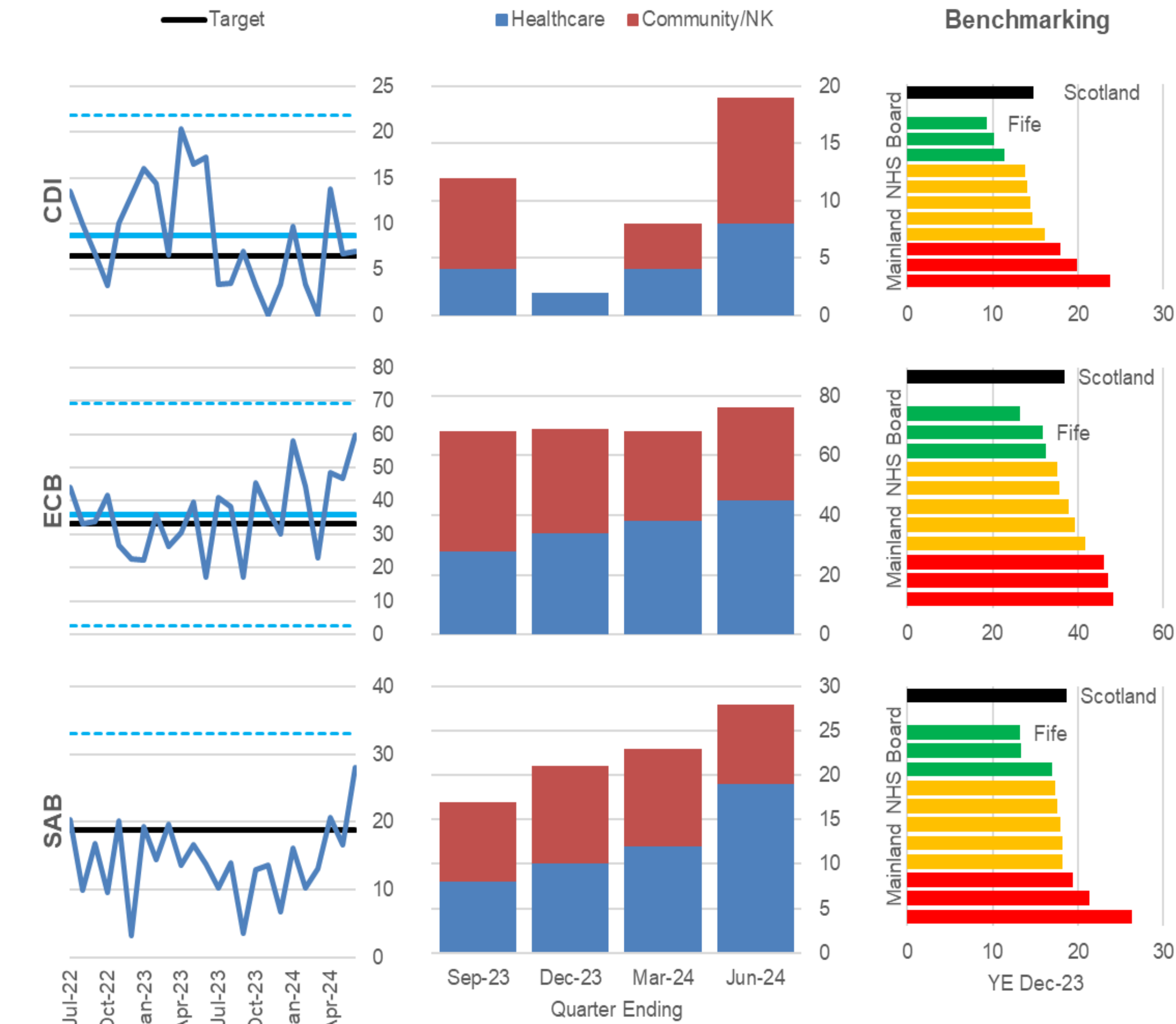
All CDI cases are assessed for risk factors leading up to the CDI infection. Previous antibiotic usage (in the 12 weeks leading up to the infection) and PPIs (Protein Pump Inhibitors) remain the most commonly seen risk factors amongst cases. A new hospital onset CDI root cause analysis form has recently been developed to assist IPCT Nurses to review each CDI patient with a more holistic approach.

The **ECB HAI/HCAI** rate increased to 59.6 in Jun-24 with number of healthcare infections increasing from 14 in May-24 to 17 in Jun-24. The cumulative number of HCAI infections over last 12 months (n=145) is higher than the same period previous year (n=112) and this increase is also seen in the number of CAUTI related ECBs. Urinary Catheter related infections have been responsible for 33 of the 145 infections in the last year (22.8%) the 'Not Known' category accounts for 22.8% of reported HCAI infections.

Regular Urinary Catheter Improvement Group (UCIG) meetings continue to take place. The aim of the group is to establish CAUTI reduction improvement work. A Urinary Catheter insertion/maintenance electronic tool continues to be developed for Patientrak, with the hope of near future rollout. Each CAUTI related ECB is reported on Datix and undergoes a CCR to ascertain any learning. Monthly meetings continue to take place to explore and discuss recent cases.

The **SAB HAI/HCAI** rate was 28.0 in Jun-24, with the rate rising to its highest level in the last 24 months. Of the 48 HCAI cases reported in the last 12 months, 14 have been categorised as 'Vascular Access Devices (VAD)' with 11 'Other' or 'Not Known' and 4 as 'Device Other Than VAD'. The cumulative number of HCAI cases in last 12 months (n=49) was lower than during the same timeframe the previous year (n=53).

VADs remain a challenge for hospital acquired SABs and ongoing work continues. All dialysis line related SABs will undergo a Complex Care Review (CCR) to ascertain learning. SABs have been removed from the Risk Register due to NHS Fife achieving the LDP target set for 2023/24.



Complaints

At least 80% of Stage 1 complaints will be completed within 5 working days by March 2025 — **59.5%** — 8 closed on time to achieve target

At least 60% of Stage 2 complaints will be completed within 20 working days by March 2025 — **20.5%** — 13 closed on time to achieve trajectory

C1. Quality & Care

Data Analysis

There were 36 Stage 1 complaints received in July-24, with 37 closed. Of those closed 22 (59.5%) were within timescales. 61% of 41 complaints that were due in the month, were closed on time.

There were 25 Stage 2 complaints received in July-24, all acknowledged within timescales, with 44 closed. 18.2% of 33 complaints that were due in the month, were closed on time.

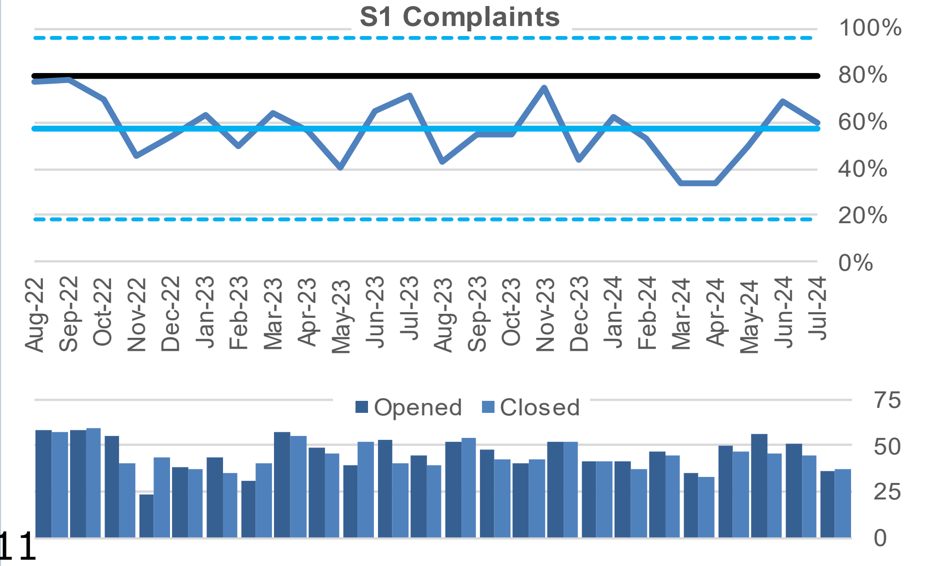
At the beginning of Aug-24, there were 2 stage 1 complaints over 70 days, 7 stage 2 complaints over 81 days, with 1 more than 161. There are now only 3 complaints over 100 days with 1 over 200 days. This shows significant progress in reducing delayed complaints.

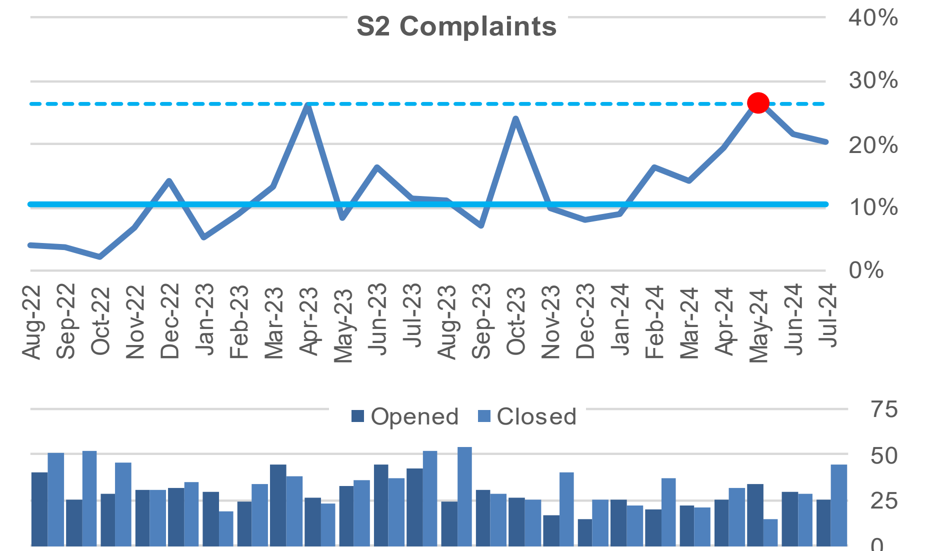
Achievements & Challenges

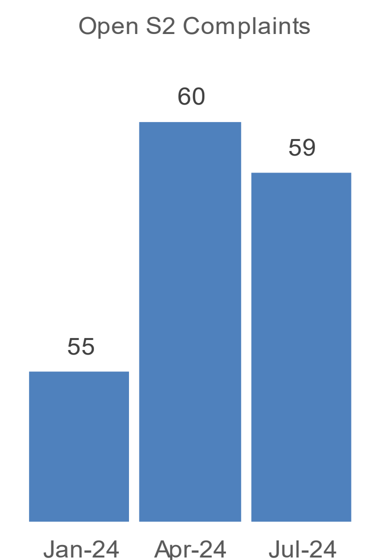
There are ongoing staffing challenges within the Patient Experience Team (PET), the team's dedication remains unwavering. The addition of absences has caused delays, impacting our ability to respond to concerns, enquiries, and complaints within timeframes. The main focus and priority complaints and weekly meetings continue to support the progression of cases, with any barriers or delays being promptly escalated to the Head of PET as required and internal escalation within the Services. Challenges with the compliance of the Stage 1 Concerns and Enquiries process across Acute and the H&SCP continue. Work is being done with services to remind them of the benefits of early resolution and encourage contact with the complainant by telephone or face-to-face in the first instance. Some services are opting to provide written responses for Stage 1 concerns, enquiries, and concerns, which causes delays within the process.

Significant efforts have been made to reduce the number of complaints over 100 days, with only 3 complaints over 100 days and o1 over 200 days. Of the 3 over 100 days. The other 2 are complex and involve a Significant Adverse Event Review (SAER), but progress is being made. The one over 200 days is complex and involves a SAER with additional questions from the complainant following feedback from the SAER meeting with the family.

The new Stage 2 Investigation Template has been tested in the Medical Directorate, with positive feedback received. It has now been shared with all services for their comments. The aim is to reduce the burden of providing a complaint response with a more streamlined form and to enhance the quality of the response with a checklist of what makes a good statement. Following a review of any returned comments, the aim is for the template to go live across all services by the end of August 2024. The PET has continued complaints training within services, with further training sessions scheduled for Aug and Sep 2024.







NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Healthcare Associated Infection Report**
Responsible Executive:	**Janette Keenan, Director of Nursing and HAI-Executive**
Report Author:	**Julia Cook, Infection Control Manager**

Executive Summary

***Clostridioides difficile* infections (CDIs)**:
- There has been a reduction in the number of CDI cases during 2024 (Jan-Jun).

***Staphylococcus aureus* Bacteraemia (SABs)**:
- A lower rate of SABs was recorded for year ending June 2024

***Escherichia coli* Bacteraemias (ECBs)**:
- Healthcare associated ECBs remain a challenge, higher infection rates for year ending June 2024.
- A lower rate of CAI recorded for year ending June 2024.

Surgical Site Surveillance (SSIs)
- Surveillance programme currently suspended nationally.

Hospital Inspection Team
- There have been no new inspections during this reporting period (May – June 2024)

National Cleaning Services Specification
- Quarter 1 (April - June 2024) shows NHS Fife achieving Green status

Estates Monitoring
- Quarter 1 (April - June 2024) NHS Fife achieving Green status

Outbreaks NHS Fife reporting period (May and June 2024)
- Norovirus**:** 4 new ward or bay closures due to a Norovirus or suspected Norovirus
- Seasonal Influenza: no new closures due to confirmed Influenza outbreaks
- COVID-19: 7 new outbreaks/incidents of COVID-19

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board Strategic Priorities

  1. To Improve Health & Wellbeing; 2. To Improve Quality of Health & Care Services; 3. To Improve Staff Experience & Wellbeing; and 4. To Deliver Value & Sustainability

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update for Infection Prevention and Control for August 2024 committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee update based on the most recent HAIRT circulated to the Infection Prevention and Control Committee August 2024.

2.2 Background

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

Standards on Reduction of Healthcare Associated Infections:

DL (2023) 06 on 28th February 2023 given the continued service pressures it has been agreed by Scottish Government that the previous HCAI targets will be further extended by one year to 2024. For awareness there has been no further HCAI targets set for 2024/25, therefore NHS Fife shall continue with current targets as an interim measure whilst national review continues. Please see below for LDP Standards.

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

- LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 2024, utilising 2018/19 as baseline data.
- Outcome measure - achieve 10% reduction by 2023/24 in healthcare associated infection rate - rate of 6.5 per 100,000 total bed days.

***Staphylococcus aureus* Bacteraemia SAB**

- LDP standards are to reduce incidence of healthcare associated SAB by 10% from 2019 to 2024, utilising 2018/19 as baseline data.

- Outcome measure to reduce the rate of SAB from 20.9 per 100,000 total bed days in 2018/19, 10% reduction target rate for 2023/234 is 18.8 per 100,000 total bed days.

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

- LDP standards are to reduce incidence of healthcare associated ECB by 25% from 2019 to 2024, utilising 2018/19 as baseline data.
- Outcome measure to reduce the rate of ECB by 25% from 44.0 per 100,000 total bed days in 2018/19, target rate for 2023/24 is 33.0 per 100,000 total bed days.

2.3 Assessment

SAB

- During Q1 2024 (January -March), NHS Fife was below the national rate for healthcare associated infection (HCAI).
- The total number of HCAI SABs (n=88), during the time-period July 2023 to June 2024, was lower than during the same timeframe the previous year, when there were 98 HCAI SABs.
- There were 4 PVC related SABs this year so far
- There were 4 dialysis line related SABs in 2024.

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

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

CDI

- During Q1 2024 (January -March), NHS Fife was below the national rate for HCAI and CAI.
- From July 2023 -end of June 2024, there was a reduction in the total number of CDI cases (n=41), when compared to the same timeframe the previous year (n=54). This improvement is also reflected in the number of HCAI cases (year ending June 2024, n=18 cases, compared to year ending June 2023, n= 44 cases).
- The total of Community acquired (CAI) CDIs during Jan- June 2024 (n=15) was higher than during the same time period from the previous 2 years.

Current CDI initiatives

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

ECB

- During Q1 2024 (January -March), NHS Fife was above the national rate for HCAI.
- There has been an increase in the number of ECBs, when comparing year ending June 2024 (n=281 cases) to year ending June 2023 (n=239). There was also an increase seen in the number of HCAIs and CAUTIs during the same time-periods.
- During Q1 2024 (January to March), NHS Fife was below the national rate for community acquired infection (CAI).

Current ECB Initiatives

- The Infection Prevention and Control team continue to work with the Urinary Catheter Improvement Group (UCIG).
- Infection control surveillance alert the patients care team Manager by Datix when an ECB is associated with a traumatic catheter insertion, removal or maintenance.
- Monthly ECB reports and graphs are distributed within HSCP and Acute services
- Catheter insertion/Maintenance bundles now in MORSE for District nurse documentation
- CAUTI bundles have now been installed onto Patientrack and have been trailed on V54 ward. Amendments to the tool are awaited by Patientrack, prior to this being rolled out across the board.

Surgical Site Infection (SSI) Surveillance Programme

National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

Caesarean Section SSI

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

Large Bowel Surgery SSI and Orthopaedic Surgery SSI

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

Outbreaks (May- June 2024)

Norovirus

- There have been 4 new ward or bay closures due to a Norovirus or suspected Norovirus outbreak during this time period.

Seasonal Influenza

- There have been no new closures due to confirmed Influenza outbreak during this time period.

COVID-19

- 7 new ARHAI Scotland reportable outbreaks/incidents of COVID-19 which are detailed in the HAIRT

Hospital Inspection Team
There have been no new inspections during this reporting period (May – June 2024)

Hand Hygiene

- There is currently no robust electronic recording system for reporting HH compliance from clinical areas across Fife. eHealth have recommended that LanQIP can be utilised as an interim tool to centralize HH data, until a further robust system can be put in place.

Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 1 (April - June 2024) was **96.3%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (April - June 2024) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 1 (April - June 2024) NHS Fife achieving **Green** status.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

A potential cost pressure to implement a new HH audit platform for governance and assurance.

2.3.4 Risk Assessment / Management

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

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Prevention and Control Committee August 2024.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

- Appendix 1 – Healthcare Associated Infection Report

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

Infection Prevention
and Control Team

HAIRT Report

HAIRT Report for Clinical Governance Committee on 6th September 2024

(Validated Data up to end of June 2024)

August 2024

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Published Month Year

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www.nhsfife.org

Contents

Board Wide Issues....3

Surveillance....5

Summary....18

Appendix 1 References and Links....23

Appendix 2 Categories of Healthcare & Community Infections....24

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

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

During Q1 2024 (January-March), NHS Fife was below the national rate for healthcare associated infection (HCAI).

The total number of SABs (n=88), during the time-period July 2023 to June 2024, was lower than during the same timeframe the previous year, when there were 98 SABs. This improvement is also reflected in the number of HCAI when comparing year end June 2024 (n=48) to year end June 2023 (n=53).

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

During Q1 2024 (January-March), NHS Fife was below national rate for HCAI & CAI.

The total number of CDIs (n=41), during the time-period July 2023 to June 2024, was lower than during the same timeframe the previous year, when there were 54 CDIs. This improvement is also reflected in the number of HCAI cases when comparing year ending June 2024, (n=18) to year ending June 23 (n= 44).

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

During Q1 2024 (January to March), NHS Fife was below the national rate for community acquired infection (CAI).

1.2 Challenges:

SABs

During Q1 2024 (January-March), NHS Fife was above the national rate for community acquired infection (CAI).

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs:

- There have been 4 PVC related SABs so far this year (Jan-Jun 2024). Previously 367 had passed without a PVC related SAB.
- 1 dialysis line related SAB in June 2024, bringing the Jan-Jun 24 total to 4 cases.

CDI

The total of Community acquired (CAI) CDIs during Jan-Jun 2024 (n=15) was higher than during the same time period the previous 2 years (Jan-Jun 2023, n=6 and Jan-Jun 2022, n=6). PPI was the most common risk factor seen amongst the CAI cases (67% of cases), followed by antibiotic use in the 12 weeks prior to CDI infection (53% of cases).

*E*CBs

During Q1 2024 (January-March), NHS Fife was above the national rate for HCAI.

There has been an increase in the number of ECBs, when comparing year ending June 2023 (n=239 cases) to year ending June 2024 (n=281). This increase is also reflected in the number of HCAI cases during the 2 time periods (year ending June 2023, n=112, compared to year ending June 2024, n=145). The number of CAUTIs has also risen during these time-periods (year ending June 2023, n= 25 and year ending June 2024, n= 33 CAUTIs).

HCAI targets for 2024/25

DL (2023) 06 published on 28th February 2023 advised given the continued service pressures it has been agreed by Scottish Government that the previous HCAI targets will be further extended by one year to 2024. We are awaiting further information regarding 2024/25 target.

Caesarean Section SSI/ Large Bowel Surgery SSI/ Orthopedics Surgery SSI

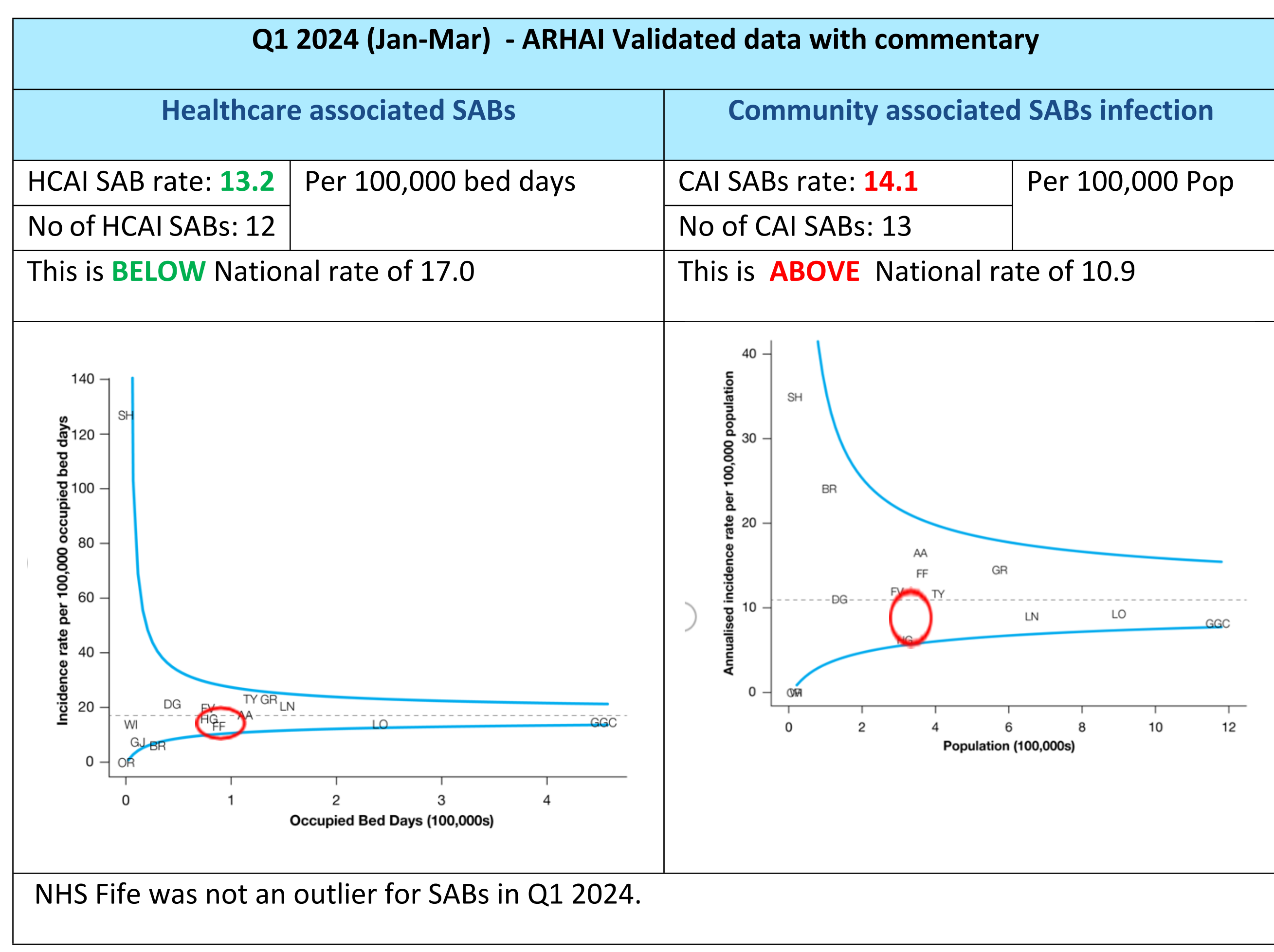
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) remains paused for the time being.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q2 2024 (Apr-Jun) **(Q2 2024 National comparison awaited)**				
In Q2 2024 NHS Fife had:	27 SABs	18 HCAI/HAI 9 CAI	This is **UP** from:	23 Cases in Q1 2024



Q1 2024 (Jan-Mar) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **13.2**	Per 100,000 bed days	CAI SABs rate: **14.1**	Per 100,000 Pop
No of HCAI SABs: 12		No of CAI SABs: 13	
This is **BELOW** National rate of 17.0		This is **ABOVE** National rate of 10.9	
NHS Fife was not an outlier for SABs in Q1 2024.			

New standards for reducing all Healthcare Associated SAB by 10% by 2024 (from 2018/2019 baseline). This standard will be locally extended for a further year to 2025		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2025**
SAB by rate 100,000 Total bed days	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**
Current 12 Monthly HCAI SAB rates for Year ending March 2024 (HPS)		
SAB by rate 100,000 Total bed days	**12.0** per 100,000 TBDs	
SAB by Number of HCAI cases	**43**	

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have been 4 dialysis line (tunnelled) related SABs during the time period January to June 2024. The cases will undergo a Complex Care Review, to ascertain learning

As of **01/07/2024** the number of days since the last confirmed SAB is as follows:	
CVC SABs	35 Days
PWID (IVDU)	70 Days
Renal Services Dialysis Line SABs	20 Days
Acute services PVC (Peripheral venous cannula) SABs	21 Days

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

2.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 637 SAB LDP Standard		
Initial Risk Level	**Current Risk Level**	Target Risk Level

Moderate 12	**Low Risk 6** **Closed 30/07/2024**	Low Risk 6

2.3 Current SAB Initiatives

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

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

2.4 National MRSA & CPE screening programme

MRSA
An uptake of 90% with application of the MRSA Clinical Risk Assessment (CRA) screening is necessary in order to ensure that the national policy for MRSA screening is effective
NHS Fife achieved **90%** compliance with the **MRSA** CRA in Q2 2024 (Apr-Jun)
This was **BELOW** Q1 2024 (95%), and **ON** the compliance target of 90%.
Awaiting national comparison for Q2 2024
MRSA Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	**Q1 2022 Jan-Mar**	**Q2 2022 Apr- Jun**	**Q3 2022 Jul-Sep**	**Q4 2022 Oct-Dec**	**Q1 2023 Jan-Mar**	**Q2 2023 Apr- Jun**	**Q3 2023 Jul-Sep**	**Q4 2023 Oct-Dec**	**Q1 2024 Jan-Mar**	**Q2 2024 Apr-Jun**
Fife	98%	98%	98%	100%	100%	98%	93%	100%	95%	90%
Scotland	81%	80%	78%	74%	78%	81%	80%	74%	79%	N/K

CPE (Carbapenemase Producing Enterobacteriaceae)
From April 2018, CRA has also included screening for CPE.
NHS Fife achieved **80%** compliance with the **CPE** CRA for Q2 2024 (Apr-Jun)
This was **BELOW** the compliance rate in Q1 2024 (98%)
Awaiting national comparison for Q2 2024
CPE Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	**Q1 2022** **Jan-Mar**	**Q2 2022** **Apr- Jun**	**Q3 2022** **Jul-Sep**	**Q4 2022** **Oct-Dec**	**Q1 2023** **Jan-Mar**	**Q2 2023** **Apr-Jun**	**Q3 2023** **Jul-Sep**	**Q4 2023** **Oct-Dec**	**Q1 2024** **Jan-Mar**	**Q2 2024** **Apr-Jun**
Fife	100%	98%	100%	100%	100%	100%	100%	100%	98%	80%
Scotland	80%	79%	78%	76%	77%	80%	81%	76%	78%	N/K

3 Clostridioides difficile Infection (CDI)

3.1 Trends

<table>
<tr><th colspan="5">Clostridioides difficile Infection (CDI)</th></tr>
<tr><th colspan="5">Local Data: Q2 Apr-Jun 2024
(Q2 2024 HPS National comparison awaited)</th></tr>
<tr><td rowspan="2">In Q2 2024 NHS Fife had:</td><td rowspan="2">19 CDIs</td><td>8 HCAI/HAI/Unknown</td><td rowspan="2">This is UP from</td><td rowspan="2">8 Cases in
Q1 2024</td></tr>
<tr><td>11 CAI</td></tr>
<tr><td colspan="5"></td></tr>
<tr><th colspan="5">Q1 (Jan-Mar) 2024 ARHAI validated data with commentary</th></tr>
<tr><td colspan="5">With ARHAI Quarterly epidemiological data Commentary
*Please note for ARHAI reporting- the CDI denominator may vary from locally reported denominators.
This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards.</td></tr>
</table>

<table>
<tr><th colspan="2">Healthcare associated CDIs</th><th colspan="2">Community associated CDIs infection</th></tr>
<tr><td>HCAI CDI rate: 4.4</td><td rowspan="2">Per 100,000 bed days</td><td>CAI CDIs rate: 4.3</td><td rowspan="2">Per 100,000 Pop</td></tr>
<tr><td>No of HCAI CDIs: 4</td><td>No of CAI CDIs: 4</td></tr>
<tr><td colspan="2">This is BELOW National rate of 12.6</td><td colspan="2">This is BELOW National rate of 7.0</td></tr>
<tr><td colspan="4">NHS Fife was not an outlier for CDIs in Q1 2024.</td></tr>
</table>

3.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 646 CDI Local Delivery Standard Target		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate 8	**Moderate Risk 8**	Low Risk 6

New standards for reducing all Healthcare Associated CDI by 10% by 2024 (from 2018/2019 baseline). This standard will be locally extended for a further year to 2025		
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2025**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**
Current 12 Monthly HCAI CDI rates for Year ending March 2024 (ARHAI)		
CDI by rate 100,000 Total bed days	**7.3** per 100,000 TBDs	
CDI by Number of HCAI cases	**26**	

3.3 Current CDI initiatives

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

- Monthly CDI reporting to Acute Services & HSCP with summary of all CDI cases
- Enhanced surveillance & HPS trigger tool completion for any triggers/ areas of concerns.
- Dr Venkatesh establishing optimum antimicrobial therapy for multiple recurrence CDI case.
- From October 2019 each CDI case is assessed for suitability of extended pulsed Fidaxomicin (EPFX) regime aiming to prevent recurrent disease in high-risk patients.
- Commercial faecal transplant (FMT) is now available and NHS Fife will use this for recurrences that have failed first and second line treatments

- Bezlotoxumab is available, only when FMT is contra-indicated, or if the patient is unable to tolerate the procedure.

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q2 (Apr-Jun) 2024 **(Q2 2024) ARHAI National comparison awaited)**				
In Q2 2024 NHS Fife had:	76 ECBs	45 HAI/HCAIs 31 CAIs	This is **UP** from	68 Cases in Q1 2024
Q2 2024 There were **8** Urinary catheter associated ECBs, which was higher than during Q1 2024, when there were 5 CAUTIs.				

Q1 (Jan-Mar) 2024			
ARHA Validated data ECBs with HPS commentary *Please note for ARHAI reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		**Community associated ECBs infection**	
HCAI ECB rate: **41.7**	Per 100,000 bed days	CAI ECBs rate: **31.4**	Per 100,000 Pop
No of HCAI ECBs: 38		No of CAI ECBs: 29	
This is **ABOVE** National rate of 35.6		This is **BELOW** National rate of 37.1	
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

New standards for reducing all Healthcare Associated ECBs by 25% by 2024 (from 2018/2019 baseline). This standard will be extended locally for a further year to 2025		
New standards for reducing all Healthcare Associated ECB by 25% by 2025 (from 2018/2019 baseline).		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2025**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending March 2024 (HPS)		
ECB by rate 100,000 Total bed days	**35.3** per 100,000 TBDs	
ECB by Number of HCAI cases	**126**	

Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals) CATHETER Device related *E.coli* Bacteraemia Count of Device- Catheter over Total Fife **HAI** ECBs			
	NHS Scotland	**NHS Fife**	Rate calculation
2024 Q2	TBC	***10.5**	
2024 Q1	TBC	*** 6.3%**	
2023 Q4	21.2%	**35.7%**	
2023 Q3	18.5%	**27.3%**	
2023 Q2	18.1%	**12.5%**	
2023 Q1	18.9%	**22.2%**	
2022 TOTAL	17.0%	**21.4%**	
2021 TOTAL	16.0%	**15.4%**	
2020 TOTAL	16.4 %	**27.5 %**	* Locally calculated data- TBC by ARHAI

2019 TOTAL	16.1 %	**24.5 %**	when Q1 & Q2 2024 data published on Discovery
Data from NSS Discovery ARHAI Indicators			

Healthcare Associated Infections (HCAI) CATHETER Device related *E.coli* Bacteraemia Count of Device- Catheter over Total Fife **HCAI** ECBs			
	NHS Scotland	**NHS Fife**	Rate calculation
2024 Q2	TBC	***23.1%**	
2024 Q1	TBC	***18.2%**	
2023 Q4	27.1%	**30.0%**	
2023 Q3	21.3%	**35.3%**	
2023 Q2	22.6%	**22.2%**	
2023 Q1	26.5%	**12.5%**	
2022 TOTAL	22.7%	**30.9 %**	*Locally calculated data- TBC by ARHAI when Q1 & Q2 2024 data published on Discovery
2021 TOTAL	27.0%	**36%**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register		
ID: 1728 ECB LDP Standard		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate Risk 12	**Moderate Risk 9**	Low Risk 6

4.3 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned in 2018 to address the issues associated with ECB CAUTI incidence and reduce the CAUI incidence. This group developed from a previous Traumatic Catheter group in 2017 which aimed to reduce the incidence of Catheters associated with trauma. The IPCT continue to attend and contribute towards the UCIG last held on 13th June 2024. This group aims to minimise urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheter insertion/maintenance/removal and self-removal, furthermore, to establish catheter improvement work in Fife.

Monthly ECB reports and graphs are distributed within HSCP and Acute services to update on the incidence of ECBs, ECB -CAUTIS (Urinary Catheters & Supra-pubic catheters) & associated trauma. During Jan-Jun 2024, there were 13 CAUTI ECBs, of which one case was associated with trauma.

Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR, to provide further learning from all ECB CAUTIs.

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and were trailed on V54 ward. Amendments to the tool are now awaited by Patientrack before this can then be rolled out across the board.

A new group has been formed, chaired by Dr Morris, to push forward the eCatheter bundles onto Patientrack (last met on 6.3.24) to quality assure the insertion & maintenance bundles. The group are working with D&I to install the bundles onto Patientrack, which will then be utilised across the acute & HSCP inpatient wards to optimise urinary and suprapubic catheter care.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections and to minimize risk.
- NHS Boards should monitor hand hygiene (HH) and ensure a zero tolerance approach to non-compliance, to provide assurance of optimum practice.
- A minimum of 20 observations are required to be audited, per month, per ward/unit.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP, which displayed the results on its dashboard.
- There is currently no robust electronic recording system for reporting HH compliance from clinical areas across Fife. eHealth has recommended that LanQIP can be utilised as an interim tool to centralize HH data, until a further robust system can be put in place.

5.1 Trends

- Unable to report

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 1 (Apr-Jun 24) was **96.3%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

- All hospitals and health centres throughout NHS Fife have participated in the National Monitoring Framework for NHS Scotland National Cleaning Services Specification. Since April 2006, all wards and departments have been regularly monitored with quarterly reports being produced through Health Facilities Scotland (HFS).

- **National Cleaning Services Specification**

Domestic Location	Q1 Apr-Jun 24	Q4 Jan-Mar 24

Fife	↑ 96.3%	96.0%
Scotland	Awaiting	Awaiting

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 1 (Apr-Jun) 24 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q1 Apr-Jun 24	Q4 Jan-Mar 24
Fife	96.8↑	96.6%
Scotland	Awaiting	Awaiting

- The Estates Monitoring – quarterly compliance report result for Quarter 1 (Apr-Jun) 24 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

· Areas with results below 90% for all Hospital & Healthcare facilities have been identified to relevant managers for action.

7.1 Outbreaks

This section gives details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none has taken place.

Where there has been an outbreak this states the causative organism, when it was declared, number of patients & staff affected & number of deaths (if any).

A summary of all outbreaks since the last report will be within Section 4.1h of the Agenda.

All ward/ bay closures due to Norovirus are reported to ARHAI Scotland weekly, all closures due to an Acute Respiratory Illness (ARI) via the ORT.

May – end of June 2024

Norovirus

There have been 4 ward/bay closures due to GI outbreaks, 2 of these were confirmed Norovirus.

Seasonal Influenza

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

COVID-19

May- June 2024, there has been 7 new COVID-19 outbreak/incident reportable to ARHAI Scotland during this reporting period.

3_Hospital	5_Ward	Ist Case	Total no. deaths	Total no. patients	Total no. staff
VHK	Ward 32	June 2024	0	2	1
VHK	Ward 10	June 2024	0	2	1
QMH	Ward 6	May 2024	0	3	0
QMH	Ward 1	June 2024	0	3	3
VHK	Hospice	June 2024	3	6	6
Cameron	Letham	June 2024	0	10	4
Glenrothes	Ward 2	June 2024	0	5	1

8. Surgical Site Infection Surveillance Programme

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

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been postponed, DL (2023) 06 published February 2023 and a subsequent DL (2024) 01 advises surgical site infection (SSI) surveillance reporting remains paused for the time being.

8 a) Caesarean section SSI

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

8 b) Hip Arthroplasty SSI

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

8 c) Hemi arthroplasty SSI

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

8 d) Knees SSI

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

8 e) Large Bowel SSI

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

9. Hospital Inspection Team

There have been no new inspections during this reporting period (May – end of June 2024)

10. Assessment

- **CDIs**: There has been a reduction in the number of *Clostridioides difficile* cases so far during 2024 (Jan-Jun), compared to Jan-Jun 2023, and this improvement is also reflected in the number of HCAI cases. CAI cases have increased during this time period and the most common risk factors seen amongst the CAI cases were PPI usage and antibiotics in the 12 weeks preceding the CDI infection. IPCT will continue to monitor and assess cases throughout the year.
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce peripheral vascular device infections have been effective but remains a challenge, with local surveillance continuing
- Ongoing monitoring of dialysis line related SABs. IPCT will support Renal service in investigating cases and any subsequent improvement strategies.
- IPCT will continue to support the Addictions Service in addressing the reduction of SABs in PWIDs
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- **SSIs surveillance** currently suspended nationally for C-sections, Large bowel surgery and Orthopaedic procedure surgeries (Total hip replacements, Knee replacements & Repair fractured neck of femurs). Awaiting further instruction regarding resumption of surveillance. Increased resources and months of preparing will be required prior to recommencing.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are categorised as:

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

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

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

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

Cleaning and Estates compliances are shown by Total Fife, VHK & QMH.

There is currently no Hand Hygiene data to submit, in the absence of a robust Hand Hygiene compliance dashboard.

Report Cards

	NHS Fife								
	SAB			C Diff			ECB		
Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI / UnKnown	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Apr-24	6	3	9	4	6	10	14	8	22
May-24	5	4	9	2	3	5	14	12	26
Jun-24	8	2	10	2	2	4	17	11	28

Cleaning Compliance (%) TOTAL FIFE												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24
Overall	95.6	95.6	95.7	96.0	96.2	95.8	95.8	95.9	96.3	96.5	96.3	96.1

Estates Monitoring Compliance (%) TOTAL FIFE												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Overall	96.1	95.7	96.2	95.7	96.2	95.9	96.8	96.6	96.3	96.9	96.9	96.7

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-24	3	3	5
May-24	4	1	6
Jun-24	6	2	6

Cleaning Compliance (%) Victoria Hospital												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Overall	95.4	95.4	95.8	96.4	96.0	95.9	95.1	94.9	95.9	96.2	95.3	95.8

Estates Monitoring Compliance (%) Victoria Hospital												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Overall	97.3	96.2	97.6	97.1	97.3	96.5	97.7	97.3	97.2	97.6	97.6	97.3

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-24	1	0	0
May-24	0	0	0
Jun-24	1	0	1

Cleaning Compliance (%) Queen Margaret's hospital												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Overall	95.8	96.6	96.4	96.8	97.4	96.6	97.0	97.5	96.7	97.7	97.4	96.5

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Overall	94.6	95.0	94.4	95.5	95.3	96.4	96.2	95.6	95.7	95.6	95.9	95.9

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	**HAI**	**HAI**	**HAI**
Apr-24	0	0	1
May-24	0	0	0
Jun-24	0	0	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	**HCAI**	Community / Not Known	HCAI / UnKnown	Community	**HCAI**	Community / Not Known
Apr-24	2	3	1	6	8	8
May-24	1	4	1	3	8	12
Jun-24	1	2	0	2	10	11

Appendix 1 References and Links

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

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI): Positive Blood culture obtained from patient who has been -Hospitalised for >48 hours If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission OR -The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained OR -A patient receives regular haemodialysis as an outpatient **Community Infection** -Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections **Not known**: -Only to be used if the ECB is not a HAI and unable to determine if community or HCAI	**Healthcare Associated Infection (HCAI):-** Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria: -Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained. OR -Resides in a Nursing home, long term facility or residential home OR -IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture, but EXCLUDING IV illicit drug use. OR -Underwent venepuncture in the 30 days before +ve BC OR -Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC OR -Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion OR -Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

HPS Linkage Origin Definitions

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

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

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

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

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

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

www.nhsfife.org

facebook.com/nhsfife
@nhsfife
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@nhsfife

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Medical Devices Update**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
	Neil McCormick, Director of Property & Asset Management
Report Authors:	**Iain MacLeod, Deputy Medical Director**
	Neil McCormick, Director of Property & Asset Management
	Gemma Causer, Associate Director of Quality & Clinical Governance

Executive Summary:

- The Scottish Government published a policy framework for medical devices in 2024. Within the framework there is an action plan which set outs 4 themes and resulting actions for NHS Boards.
- The action plan within the framework will be taken forward by the Medical Devices Group (to be chaired by the Medical Director) which reports in the Clinical Governance Oversight Group.
- In summary the current NHS Fife position against the action plan is as follows:

1. Assurance of implementation of UK Medical Device Regulations (MDR)
    - NHS Fife policies have been submitted as a part of the National review and feedback is awaited
2. Improving and utilising medical device data at national level and maximising its use to improve patient safety
    - Scan for Safety (electronic tracking of implantable devices) is scheduled for roll out in NHS Fife in September 2025
3. Improving the information available to patients about medical devices used in their care
    - To be developed in line with Scan for Safety implementation
4. Improving infrastructure for medical devices at national level
    - Monitoring of compliance through self assessment will be overseen by the Medical Devices Group

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The definition of medical devices now includes a wide range of instruments, apparatus, appliances, software, materials or other article used in the process of delivering healthcare.

Changes are required following our exit from the European Union and the Medicines and Healthcare products Agency (MHRA) have been consulting on wide-ranging changes to the regulatory framework.

The Scottish Government have recently published a Policy Framework for Medical Devices SGHD/CMO(2024)1 which is titled:

> Medical device regulation (MDR) preparedness and medical devices policy framework and action plan 2024-2026 (scot.nhs.uk)

This includes an action plan for 2024-26 which identifies 4 themes and resulting actions for Scottish Government, National Services Scotland, Health Improvement Scotland and Health Boards – this document is included at Appendix 1

2.2 Background

The MHRA is in the process of implementing changes to the Medical Devices Regulatory Framework which will come into force in a phased manner over the coming year.

This future legislation for medical devices is intended to deliver:

- improved patient and public safety
- greater transparency of regulatory decision making and medical device information
- close alignment with international best practice, and
- more flexible, responsive and proportionate regulation of medical devices

In addition, the Scan for Safety Programme will rollout Point of Care (PoC) scanning as part of the implementation of a new Inventory Management System (IMS) in a way which optimises the opportunities to improve patient safety but also has the flexibility to recognise the practicalities of implementing change in a Health Board operational environment.

The Scan for Safety Programme aims to implement a system wide approach to the tracking and tracing of high-risk implantable devices in Scotland through digital data capture at the point of care.

It will take a “Once for Scotland” approach and will capture implantable medical device data electronically in a consistent format across the NHS, including information on the patient, procedure, clinical staff, information about the device itself and where the procedure takes place.

This work will improve patient safety through enabling device traceability, supporting efficient patient recall and contribute to the wider monitoring of device performance and clinical outcomes.

2.3 Assessment

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

The Action plan contains 4 themes and a detailed action plan will be considered by the Medical Devices Group as it is developed over the coming months. Going forward the Medical Director will chair the Medical Devices Group.

Theme 1: Assurance of implementation of UK Medical Device Regulations (MDR) for NHS Boards and application of national guidance on "Management of Medical Devices in health and social care" (SHTN 00-04)

NHS Fife policies have been submitted as part of the National review and we await specific feedback following the first meeting of the National Medical Device Committee in March 24. In general (across all Boards):

- The greatest focus of those policies in place was on procurement and there was significant variance between boards.
- There was also a systemic lack of clarity on how governance flows through the organisations and how risk was managed.

It is anticipated that risks will be monitored by the Medical Devices Group and escalated to the Clinical Governance Oversight Group and if required to the Clinical Governance Committee. This needs to be considered as part of the corporate risk management framework and potentially a risk added with respect to compliance with the relevant guidance, procedures, and legislation.

Theme 2: Improving and utilising medical device data at national level and maximising its use to improve patient safety

Work in partnership with NSS to implement the NHS Scotland Scan for Safety Programme including the National Medical Equipment Management System.

- NHS Fife representation from Deputy Medical Director (Acute) and Associate Director for Quality and Clinical Governance members of Scan for Safety Programme Health Board Delivery Group
- The scheduled implementation of Scan for Safety in NHS Fife is September 2026. Initial discussions have taken place with key NHS Fife stakeholders. There will be a requirement to stand up Project Management Office (PMO) support from June/July 2026.
- Initial focus on implantable devices will focus on orthopaedics, ophthalmology, cardiology and interventional radiology.

Theme 3: Improving the information available to patients about medical devices used in their care

Consider how Boards can apply the national guidance on patient information (once published) on medical device to locally produced information.

- Once Scan for Safety is being implemented identify the changes patients may notice due to implementation of the programme, the information, which will be captured as part of the scanning process and how this will be stored and used.

Theme 4: Improving infrastructure for medical devices at national level

A national monitoring and evaluation framework and self-assessment tool for Boards is being developed to support compliance with regulation and existing national policy guidance.

- Implement the national Monitoring and Improvement Framework when available

- Use the national workforce planning process to signal any changes in workforce requirements required for MDR compliance.

- Initial discussions within NHS Fife and an independent review carried out by a neighbouring Health Board have identified that there is a requirement for a lead Medical Devices Manager to take forward the work identified in this action plan. Subsequently the NHS Fife Compliance Manager has been identified as the lead for medical devices.

The Medical Devices Group will agree a workplan to ensure that that action plan is implemented. This group will also create connection with the recently established Innovation Group so support the implementation or introduction of emerging medical device innovations.

2.3.1 Quality / Patient Care

This work will improve the quality and safety of patient care through improved traceability and efficiency of use of medical devices.

2.3.2 Workforce

There should be no immediate impact on workforce other than the requirement to identify a lead Medical Devices Manager to take forward the work identified in this action plan

2.3.3 Financial

There are potential efficiencies that can be delivered through the traceability and efficient use of medical devices and equipment.

2.3.4 Risk Assessment / Management

The majority of risks identified would be as a result of not being able to implement future guidance and legislation.

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

An EQIA Impact Assessment has not yet been carried out.

2.3.6 Climate Emergency & Sustainability Impact

There is potential for old equipment to be recycled and or repurposed for use by charities.

2.3.7 Communication, involvement, engagement and consultation

A communication plan will be developed at a future date.

2.3.8 Route to the Meeting

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

- Clinical Governance Oversight Committee, 16 April 2024
- EDG, 18 April 2024

2.4 Recommendation

- This paper is provided to members for a **"moderate"** level of assurance that a detailed plan will be produced for the Medical Devices Group which will address the points in the National Framework

3 List of appendices

- Appendix 1 - Medical Device Regulation (MDR) Preparedness and Medical Devices Policy Framework and Action Plan 2024-2026

Report Contact
Neil McCormick
Director of Property & Asset Management
Email neil.mccormick@nhs.scot

Chief Medical Officer for Scotland

E: CMO@gov.scot

Dear Colleague

MEDICAL DEVICE REGULATION (MDR) PREPAREDNESS AND MEDICAL DEVICES POLICY FRAMEWORK AND ACTION PLAN 2024-2026

Purpose

1. To provide NHS Boards with the Medical Device Policy Framework and Action Plan which has been developed to support Boards to achieve compliance with proposed changes to UK Medical Device Regulation (MDR).

Context

2. The planned revision of the UK medical devices regulations (UK MDR), by the UK Medicines and Healthcare products Regulatory Agency (MHRA), designed to improve patient safety will introduce new and additional legislative requirements for NHS Boards, particularly for in house manufactured devices, software as a medical device and high risk implantable devices.

3. The Medical Devices Policy Framework and Action Plan (Annex A) is focussed on MDR preparedness and improving the foundations needed to support medical devices policy, and has been developed through engagement with NHS Boards and Local Authority Incident Safety Officers.

4. The Framework's Action Plan sets out the key Actions to be progressed in the period 2024-2026, mainly for the SG Medical Devices Unit (MDLU) in partnership with the NHS Scotland Scan for Safety Programme being led by NSS, the national Incident Reporting and Investigation Centre (IRIC) also NSS and with support from Health Improvement Scotland (HIS).

5. The 9 Actions for Health Boards are based on existing requirements in CEL 35 (2010) and CEL 43 (2009) with a focus on improving local assurance processes for MDR compliance and the safe management of medical devices, utilising the outcome of the national actions.

Summary

6. The Framework **aim is to improve patient safety and outcomes in medical devices** through four key themes.

From the Chief Medical Officer for Scotland
Professor Sir Gregor Smith

8 February 2024

SGHD/CMO(2024)1

Addresses

For action
Chief Executives, NHS Boards
Executive Directors responsible for Medical Device Policies, NHS Boards

For information
Chairs, Board Medical Device Committees
Incident and alerts Safety Officers (ISON), NHS Boards and Local Authorities
IRIC
Clinical Engineering Leads
Nurse Directors
AHP Directors
Healthcare Science Leads
eHealth Leads, NHS Boards
COSLA
SOLACE
Diagnostics Steering Group
PHS SNAP Programme
Medical Devices Committee (MDC)
SHTG

Enquiries to:

Kerry Chalmers
Medical Devices and Legislation Unit
St Andrew's House
EDINBURGH EH1 3DG

Tel: 07825 356050
Email: kerry.chalmers@gov.scot

- **Assurance of implementation of UK MDR** relating to primarily NHS Boards and the application of national guidance on "Management of Medical Devices in health and social care" (SHTN 00-04) in Scotland:
- **improving and utilising medical device data at national level** and maximising its use to improve patient safety;
- **improving the information available to patients** about medical devices used in their care; and
- **improving infrastructure for medical devices at national level** with a first key step the establishment of a national Medical Devices Committee.

7. A national Medical Devices Committee has been established, co-chaired by the Chief Medical Officer and on behalf of NHS Board Chief Executives, Gordon James, to provide leadership and offer direction to NHS Scotland in its preparation for the medical devices regulatory regime, due to be in effect from summer 2025. Draft Terms of Reference provided in Annex B.

8. The Actions in this Framework are intended to be the start of the key foundations for developing medical devices policy in NHS Scotland. Implementation of this first Framework, covering the period 2024-2026 will enable an evidence based medical device policy to evolve.

NHS Scotland Scan for Safety Programme

9. The NHS Scotland Scan for Safety Programme will implement point of care scanning to link patients to implantable devices used in their care and is due to be completed by March 2026. The Scan for Safety Programme, led by NSS, is working in partnership with Health Boards to deliver electronic traceability of high risk medical devices and ensure that Health Boards comply with the future Medical Device Regulation requirements.

10. A further CMO letter will follow specifically on this.

Monitoring and Evaluation

11. A monitoring and evaluation framework and self-assessment tool for Boards is being developed as part of this Framework. The SG MDLU will be undertaking regular reviews of progress reporting to the newly established Medical Devices Committee (MDC).

Action for Boards

12. NHS Board Executive Directors responsible for medical device policies are asked to take forward the Board Actions relevant to them through their local Board Medical Device Committee.

Yours sincerely

Gregor Smith

Professor Sir Gregor Smith
Chief Medical Officer for Scotland

Annex A

Medical Devices Policy Framework and Action Plan

Introduction

The Medical Devices Policy Framework and Action Plan, developed through engagement with NHS Boards and Local Authority Incident Safety Officers, encompasses several existing programmes of work, including improving preparedness for Medical Device Regulations (MDR) planned to come into force in July 2025.

The Framework **aim is to improve patient safety and outcomes in medical devices** delivered though four key themes:

- **Assurance of implementation of UK MDR** relating to primarily NHS Boards and the application of national guidance on "Management of Medical Devices in health and social care" (SHTN 00-04) in Scotland:
- **improving and utilising medical device data at national level** and maximising its use to improve patient safety;
- **improving the information available to patients** about medical devices used in their care; and
- **improving infrastructure for medical devices at national level** with a first key step to establish a national Medical Devices Committee.

Preparing for the future – laying the foundations for future Action Plans

These actions are intended to be the start of the key foundations for developing medical devices policy in NHS Scotland. Implementation of this first Framework and Action plan, covering the next 2 years will enable an evidence based medical device policy to evolve.

Key Themes and Action Plan 2024-2026

Theme 1: Assurance of implementation of UK Medical Device Regulations (MDR) for NHS Boards and application of national guidance on "Management of Medical Devices in health and social care" (SHTN 00-04)

Why this matters

The process to develop the future UK Medical Device Regulations by the Medicines and Healthcare products Regulatory Agency (MHRA) is underway with future regulations due to come into effect in a three phased approach; Transitional Arrangements (Laid 2023), Post Market Surveillance (Implementation Summer 24), Future core MDR (July 2025).

The UK Government published response to the public consultation on the future regulation of medical devices provides the direction and intention of the future regulatory framework. High impact areas for Health Boards and Local Authorities include significant changes to Health Institute Exemption relevant to in-house manufacturing, Software as a Medical Device, requirements regarding storage Unique Device Identifiers linked to patients for high risk implantable devices.

Actions 2024-26

Scottish Government:
Baseline current NHS Board positions on medical device policy development, their scope and governance.

Provide guidance to support Boards to develop local medical devices policies that provide assurance of management of medical devices compliance with regulatory requirements and integrates with other Board safety and governance structures.
Establish a SLWG with the Clinical Engineering and eHealth communities to develop guidance and a Once for Scotland approach where possible on the management of Software as a Medical Device (SaMD).
National Services Scotland should:
Update the national "Guidance on the Management of Medical Devices in Health and Social Care" to reflect the changes in MDR and developments in the medical devices landscape in Scotland.
Undertake, through the Incident and Safety Officers Network (ISON), an MDR preparedness gap analysis on In House Manufacture by Health Institutions including the extent to which ISO 13485 or equivalent QMS is being implemented.
Establish a SLWG to develop a Monitoring and Improvement Framework to measure Boards/LAs compliance against "Guidance on the Management of Medical Devices in Health and Social Care" (which includes appropriate MDR requirements).
Health Improvement Scotland should:
Ensure the pipeline from evidence to adoption of new medical device health technology assessments is enhanced through engagement with Boards and key stakeholders.
NHS Boards should:
Review local NHS Board medical device policies and governance structures in line with "Guidance on the Management of Medical Devices in Health and Social Care" and MHRA regulatory requirements to identify gaps and produce a local Action Plan.
As part of Board's local governance structures consider how MDR compliance risks will be monitored and escalated at Board level.
Ensure their medical device polices are linked to governance processes that support the implementation of the relevant Scottish Health Techologies Group (SHTG) health technology assessments.

Theme 2: Improving and utilising medical device data at national level and maximising its use to improve patient safety

The Covid 19 pandemic exposed the challenges in identifying supply and use of key medical devices and equipment and has resulted in significant investment to improve particularly supply chain knowledge of devices and equipment. Baroness Cumberlege's Independent Review of Medicines and Medical Devices (Cumberlege Review) documented the significant limitations for traceability and record keeping for transvaginal mesh and made key recommendations to establish a national database linking medical devices and patients.

What we are doing

The NHS Scotland Scan for Safety Programme led by NSS, in partnership with NHS Boards, will deliver a national approach to traceability for high risk implantable devices used in acute care and provide a source of data to improve safety, knowledge and outcomes for medical devices.

Actions 2024-26

Scottish Government should:
In partnership with the Scottish Government National Audit Programme Board (SGNAPB) and Scottish National Audit Programme (SNAP), promote the linkage of device data into clinical outcome data collections.
Work closely with the Scan for Safety Programme in considering how we can support national medical device data to deliver value and impact.
National Services Scotland should:
Work in partnership with NHS Boards to implement the NHS Scotland Scan for Safety Programme, with a focus on high risk implantables until 2026.
Develop a National Reporting Framework to confirm how the medical device data which will be made available through Genesis and Medical Devices Data Hub will be used and shared.
Develop a National Reporting Framework to confirm how the data which will be made available through the National Medical Equipment Management System (NMEMS) will be used and shared.
NHS Boards should:
Work in partnership with NSS to implement the NHS Scotland Scan for Safety Programme including the National Medical Equipment Management System.
Following the pilot and evaluation of the Pelvic Floor Registry (PFR), implement across all Boards; and improve ascertainment in the Breast and Cosmetic Implant Registry (BCIR) to inform improved outcomes for patients and services.

Theme 3: Improving the information available to patients about medical devices used in their care

Why this matters

Patient and citizen insight in the design, planning and delivery of medical device improvements are essential in ensuring we deliver what is important to patients in a person-centred health and care system.

What are we doing

Initial discovery work including a literature review by Health Improvement Scotland on patient experiences and opinions about medical devices have provided valuable insights that will be used to guide medical devices policy as well as shape future patient involvement. The MDLU and the SFS programme in partnership with the HIS Gathering Views programme are undertaking patient insights work on medical devices to ensure patient views is built into the foundation of the work of MDLU and the SFS programme.

Actions 2024-26

Scottish Government should:
Develop a guide for NHS Boards and local authorities on best practice in providing information to patients about medical devices.
Health Improvement Scotland should:

Working in partnership with the MDLU and Scan for Safety Programme undertake citizen engagement to build a better understanding of patient attitudes to, for example, receiving information about devices used in their care, and to reporting adverse events with devices used in their care through their Gathering Views process.
National Services Scotland should:
Provide information to those sites where Scan for Safety is being implemented covering: the changes patients may notice due to implementation of the programme, the information which will be captured as part of the scanning process and how this will be stored and used.
NHS Boards should:
Consider how Boards can apply the national guidance on patient information on medical device to locally produced information.
Consider how local initiatives can support patients to report issues and adverse events related to medical devices.

Theme 4: Improving infrastructure for medical devices at national level

Why this matters

The infrastructure to support the safety, management and improvement for medical devices requires review. Local Board policies and structures are varied and in some Boards this will form a significant challenge to achieving assurance of compliance with a new and more complex regulatory regime. At national level, there are limited national forums for escalation or opportunities for leadership, sharing knowledge and delivering a national approach to challenges.

Governance and Accountability

As a first step, a national Medical Device Committee (MDC)) has been established to provide leadership and offer direction to NHS Scotland. A Medical Devices Regulation Community on Teams has also been established to facilitate knowledge and best practice sharing.

Monitoring and Improvement

The journey for improvement in medical device safety, Board structures and roles and assurance of compliance with regulation and national policy will take a number of years. Working in partnership with Boards, we will develop a monitoring and improvement framework to support the compliance with regulation and existing national policy guidance

What we are doing in 2024

Scottish Government:
Establish a national Medical Device Committee to provide leadership and guidance on MDR Preparedness and the national Actions in this Framework
Input to the monitoring and improvement framework for compliance with UK MDR and national policies and guidance.
With NHS Education for Scotland (NES), create national medical device regulation education and training resources for health and social care staff, hosted on TURAS
Establish an Medical Device Regulation Community to share opportunities for sharing knowledge and best practice across the system

NHS Boards should:
Implement the national Monitoring and Improvement Framework when available
Use the national workforce planning process to signal any changes in workforce requirements required for MDR compliance

SG Medical Devices Committee – Draft Terms of Reference (Abbreviated Version)

1. Purpose of Medical Devices Committee (MDC)

To provide leadership and offer direction to NHS Scotland in its preparation for the medical devices regulatory regime due to be in place by 2025.

2. Responsibilities

The Committee will:

- Seek to add to preparedness, including by commissioning SLWGs through the SG Medical Devices and Legislation Unit (MDLU) with the relevant Subject Matter Expertise (SME) to develop Once for Scotland approaches and/or national guidance, where possible and considered useful.

- Oversee the development of mechanisms to provide assurance of compliance with regulatory and supporting national guidance for NHS Boards, particularly through local Board medical device policies and ensuring the development of a Monitoring and Improvement Framework, that NHS Boards can use to measure their compliance against national guidance.

- Advise the SG Medical Devices Unit about the delivery of a Scottish Government Medical Device Policy Framework which is being considered (which will have the aims of supporting NHS Boards with their regulatory compliance and improving patient safety and outcomes in medical devices).

- Where existing national structures are in place, the role of the Committee will be to direct those to the most appropriate structures. For example, particular service issues which would be for their respective governance routes such as Diagnostics Steering Group, Digital Portfolio Board or National Infrastructure Board.

Chair and Membership

Co-chaired by CMO and Gordon James on behalf of NHS Board Chief Executives with membership at Board Executive Director level and Subject Matter Experts.

Meeting Dates for 2024

- 15 March 2024
- 29 May 2024
- 28 August 2024
- 21 November 2024

January 2024

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Organisational Learning**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gemma Couser, Associate Director for Quality and Clinical Governance and Jenni Jones, Associate Director for Culture, Development and Wellbeing**

Executive Summary:

- This paper sets out the approach being adopted to build on our capability as a learning organisation. Creating conditions to allow collaborative learning across our full healthcare system is at the core of the approach. This work currently majors on clinical learning but it is recognised that there could be wider benefit in extending the reach of this work.
- The approach uses Myron's Maxims, a set of enabling living system principles, combined with the formal organisational requirements of governance, system and process.
- The Organisational Learning Leadership Group oversees this work and is comprised of a group of self selected leaders who are committed to taking forward this complex and adaptive agenda.
- The work is intended to augment our current systems of governance and learning - not to replace.
- 2024/2025 is being used an opportunity to implement key foundations on which this work can be developed into next year and beyond. The Organisational Learning Leadership Group delivery plan includes:

  i. Developing an infrastructure for learning
  ii. Increased focus on improvement activities through governance structures
  iii. Developing a learning system framework
  iv. Legal claims: Learning from and improving governance
  v. Quality improvement
  vi. Creating connections to learn and improve (data)

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board Strategic Priority/ies:
    - To Improve Quality of Health & Care Services
    - To Improve Staff Experience & Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The organisational learning work described in this paper aspires to place greater emphasis on learning and improve our capability. Overwhelmingly most clinical interactions are positive. Moreover there is lots of innovative and forward thinking practice being driven by our clinical teams. Combined this presents an opportunity to celebrate success and share positive learning for others to adapt and adopt. As to be expected in this complex system things don't always go to plan and when they don't it is of critical importance that we learn from this to make improvements and mitigate the chances of recurrence.

This work is intended to augment and place emphasis on learning across our existing clinical governance structures and not to replace the fundamental quality and safety governance processes.

This paper sets out:

i. Ethos of the Organisational Learning work and why it was established;
ii. Articulates the approach adopted by the Organisational Learning Leadership Group and;
iii. The Organisational Learning Workplan 2024/2025

It should be noted that the focus of this work is on clinical governance organisational learning, however it is recognised that the development of a framework may bring benefit to wider to non-clinical activities.

2.2 Background

The Aim

The NHS Fife Clinical Governance Strategic Framework sets out an aim to "Deliver, safe, effective, person centred care in an organisation which listens, learns and improves.

Fundamentally the aim of the Organisational Learning Leadership Group is to develop our capability as a learning organisation to reduce and avoid preventable patient harm and improve quality and experience.

A significant amount of time is invested across the organisation investigating adverse events, responding to complaints, and carrying out clinical audits. There is a requirement for us to create conditions to ensure that, where relevant, the learning and improvements from good practice and practice requiring improvement is shared widely and embedded across the organisation.

> *"Even apparently simple human errors almost always have multiple causes, many beyond the control of the individual who makes the mistake. Therefore, it makes no sense at all to punish a person who makes an error, still less to criminalise it. The same is true of system failures that derive from the same kind of multiple unintentional mistakes. Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them.*
>
> *The best way to reduce harm ... is to embrace wholeheartedly a culture of learning."* A promise to learn – a commitment to act, The National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, August 2013

Learning Opportunities

The table below summarises some of the key activities which present an opportunity for

Learning from the Past	Responding to the present and emerging issues	Proactive response for the future
• Adverse Events • Complaints • Care Opinion • Litigation • Fatal Accident Inquires • Duty of Candour • Whistleblowing • External reviews/reports/inspections • Audit • Learning from experience from other health organisations	• Audit • Clinical governance key quality performance indicators e.g. cardiac arrest, falls, pressure ulcers, healthcare associated infections • Adverse event themes e.g. near miss	• Corporate Risk Register • Risk register at service/directorate level • Planning for quality

Learning and any associated improvements need to take place at the most appropriate level in the organisation i.e. from ward to Board. At an organisational level there is a

requirement to ensure that have we have leadership, systems and processes in place to facilitate shared learning and identify themes where there is an opportunity for an organisational response or learning.

The Organisational Learning Group

In late 2021 the Organisational Learning Group (OLG) was established and is now known as the Organisational Learning Leadership Group (OLLG). Today the membership of the group is:

Deputy Medical Director (co-chair)
Nurse Director, Corporate (co-chair)
Associate Director for Quality and Clinical Governance (co-chair)
Lead for Adverse Events
Portfolio Manager and QI Lead
Associate Director for Development, Culture and Wellbeing
Lead Pharmacist for Medicines Safety
Clinical Effectiveness Manager
Head of Quality and Clinical Governance, HSCP
Director of Nursing, HSCP
Associate Director of Medical Education (TBC)

The group was established through organic discussion with key stakeholders who were eager to improve the capability to learn at an organisational level. The group's remit initially was to ensure that learning gained from clinical experiences which is relevant across the wider organisation is used to optimise patient safety. The group acknowledged that the wider organisational context is more complex that individual learning environments. The challenge to fulfil the ambitious remit of the OLG was recognised. At the outset, there was consensus that the concept and aspiration were correct, however concerns were identified in terms of ensuring the OLG delivered tangible positive impact.

2.3 Assessment

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

Review of the Organisational Learning Leadership Group

Core members of the OLLG reviewed the activities of the group during 2023. Recognising the complexity of achieving the remit of the OLLG the following guiding principles have been identified to progress a refreshed approach in 24/25:

1. The OLLG should support creating conditions to share of key information and feedback around what is happening across the organisation and that key messages from one part of the organisation are spread to another e.g. learning from adverse events or quality improvement projects

2. Build on the organisational ability to triangulate learning to contribute to the understanding of the bigger picture – getting the full system overview and defining how this will be brought into practice

3. The requirement to sharing 'positive' learning where things are working well as well as where we need to improve

4. The approach to organisational learning should augment and support existing clinical governance structures and activities and not seek to replicate- with a focus on developing mechanisms to capture and share key learning for the organisation

5. Activities to progress organisational learning must add value

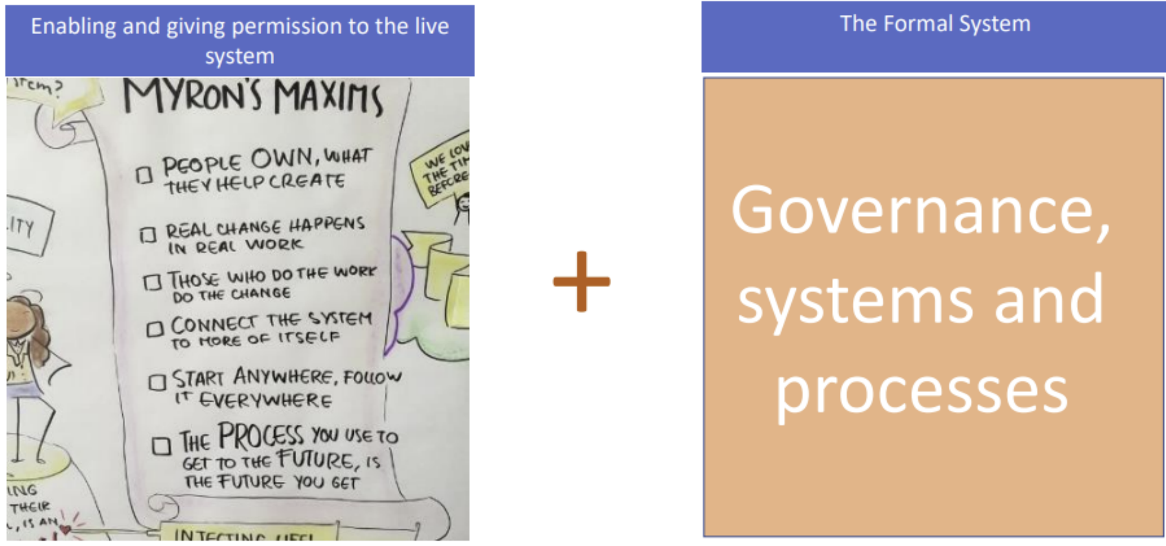
6. Leaders committed to progressing this work need to be prepared to take an iterative and learning approach to developing the best way forward

7. An Organisational Learning Framework should be developed which:
    - Promotes organisational learning as a priority and aligns to our values
    - Outlines a suite of activities which are implemented to support organisational learning
    - Defines the approach for capturing and sharing of key learning and improvement activities- both good practice and areas identified for improvement and that this is owned at the appropriate level in the organisation.
    - Describes the approach to the triangulation of data and intelligence
    - Aligns to NHS Fife organisational values and to the NHS Fife Clinical Governance Strategic Framework 2022-2025
    - Weaves into and augments existing clinical governance structures

The OLLG will provide assurance to the Clinical Governance Oversight Group and the Executive Directors Group. Further consideration is required to define the reporting lines of this work given the evolving nature of what is proposed.

The Approach

The approach adopted combines using Myron's Maxim's system principles which give permission to the living system with the need to design governance, system, and process within our formal organisational structure:



Delivery Plan 24/25

The Organisational Learning Leadership Group delivery plan for 24/25 majors on laying the foundations on which to further build our organisational learning capability. It is a plan which recognises the importance of people, culture, governance systems and process. The full delivery plan is contained in appendix 1 and covers the following workstreams:

i. Developing an infrastructure for learning
ii. Increased focus on improvement activities through governance structures
iii. Developing a learning system framework
iv. Legal claims: Learning from and improving governance
v. Quality improvement
vi. Creating connections to learn and improve (data)

Progress so Far

Two key pieces of work progressed so far are the proposed development of:

- Learning from Clinical Experience Collaborative and;
- Legal Claims: learning from and improving governance.

Detail on this work is set out in the sections below:

Learning from Clinical Experience Collaborative (Action: 1.2)

The aim of the collaborative is to developing a clinically led learning forum to shine a light on learning from clinical experience with embodies an ethos which is:

- Patient centred

- Clinically led
- Of global relevance for multi-professions across our full health system
- Values based and aspires to foster a culture of learning and "no blame"
- Positive, engaging and purposeful for those who attend (possibly CPD contribution via TURAS) – participating and attending must not be a chore
- Connects multi-professionals (including those in training) across our health system
- Focused on celebrating success as well as learning where improvement opportunity is identified
- Appreciative of the value and importance of teams learning together

The programme for the events needs further refinement but initial proposal would be:

- Celebrating success stories e.g. robotic surgery and impact on patient experience and length of stay
- Examining themes from care opinion, patient complaints and adverse events which could be clustered and shared along with any improvement opportunities
- Sharing of big pieces of improvement work e.g. Deteriorating Patient Programme
- Bite size/ micro learning e.g. a focus on human factors with input from subject matter experts
- Patient stories

The proposal has been shared widely across divisions for feedback and to seek involvement from clinical teams. The aim is to launch the Collaborative before March 25.

Legal Claims: Learning from and Improving Governance (Action 5.1)

This work focuses on ensuring that legal claims are used to inform further quality and safety improvements across our healthcare system. The key objective is how we use the learning from claims, similar to the approach for adverse event reviews, in order to mitigate recurrence. The role of the Organisational Learning Leadership Group with this work is to provide a steer in the approach that is adopted to achieve the aim described. Further to a review of the legal systems and processes in NHS Fife a paper was provided to Executive Directors (EDG) in August 24 to gain a strategic steer on the recommendations set out in appendix 2.

The recommendations were supported by EDG and work is now underway to deliver the recommendations with a further update to be provided at EDG in September 24.

Enablers and Contributors

Other activities which will contribute and enable this work include:

- Review of adverse events policy and procedure
- Development and implementation of a human factors approach to adverse event investigation
- Development of “Our Leadership Way”
- Consideration of staff governance indicators to indicate potential cultural flags
- NHS Fife Quality Network
- Risk Management Framework

Measuring Success

It is important that that this work demonstrates tangible impact. How this will be assessed is yet to be determined by OLLG.

2.3.1 Quality, Patient and Value-Based Health & Care

Supporting the organisation to reduce avoidable patient harm, improve the quality of care and supporting wellbeing outcomes through learning and improvement is the aim of this work.

2.3.2 Workforce

One of the key principles to this work is the inclusion of staff; both in terms of feedback and the design of improvement activities. In addition the proposal to focus on a human factors approach aligns with a just culture that does not seek to attribute blame.

2.3.3 Financial

The challenging financial climate is clearly recognised. The approach outlined seeks to enable high quality services which are efficient. The objectives of the Reform, Transform and Perform programme will be considered in the design of this work.

2.3.4 Risk Assessment / Management

This work seeks to mitigate corporate risk 9:

Quality and Safety- There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.

One of the root causes of this risk is that there is “no effective system of supporting effective organisational learning is one of the root causes of this risk”.

2.3.5 Equality and Human Rights, including children’s rights, health inequalities and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

- Organisational Learning Leadership Group
- NHS Fife Board Development Session 27 August 2024
- Approach has been discussed with the Chief Executive and the Medical Director

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.

- Clinical Governance Oversight Group, April 2024

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance, with 2024/25 being used as the year to focus on laying foundations on which to build on this work.

This paper is also provided to members for **discussion** – for examining and considering the implications of the matter.

3 List of appendices

- Appendix 1 - Organisational Learning Leadership Group Delivery Plan 2024/25
- Appendix 2 - Legal Claims: Learning from and Improving Governance Recommendations

Report Contact
Gemma Couser
Associate Director for Quality and Clinical Governance
Email gemma.couser2@nhs.scot

Organisational Learning Leadership Group

Delivery Plan 24/25

Delivered	On track	Not started	At risk

1.	**Development of infrastructure for learning** • **Increase organisational visibility and dialogue relating to learning and improvement activities** • **Facilitate organisational level connection with staff to help access learning and improvement activities** • **Create a system to connect and exchange learning and quality improvement** • **Support concept of double loop learning**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**
1.1	Staff blink learning from experience hub	Space to share learning at an organisational level	Nov 24	CF	P
1.2	Learning from Experience Event (previous Inter-specialty Event)	Create a forum for all clinicians and staff to share learning from their experience (complaints, SAERs, compliments, SPSO)	Sept 24	NR/IM/GC	P

1.3	Mapping of learning activities	Identify areas of good practice currently and connect e.g. Medicines Drumbeat, Deteriorating Patient, ASD SAER feedback, M&M meetings	Aug24		G&P

2.	**Increased focus on improvement activity through governance structures** **Reporting key quality performance measures such as adverse events and complaints focus on numbers of events or delivery against targets for completion.** **There is an opportunity strengthen the visibility of the response to QPIs and what is happening organisationally to address**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**
2.1	Improve visibility on improvement measures and activity	Aligned to Board assurance measures ensure that improvement plans for SAER outcomes are aligned to the following: Outcome 4- SAER Panel Outcome 3- Divisional Clin Gov Outcome 1&2- Service Clin Gov	Aug 24	CF/GC	G&P
2.2	Organisational learning ward to Board	Addition of Organisational Learning to Clinical Governance agendas	Jan 24	CG/CG/IM	G&P

3.	**Development of a Learning System Framework** • **A framework which sets out the ethos of organisational learning and defines a suite of activities from ward to Board**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**
3.1	Organisational Learning Group	Leadership continue to meet bi- monthly to oversee workplan and define approach. Recommend ToR is disbanded and redefined at end of 24/25	Mar 25	ALL	G&P
3.2	Organisational Learning Framework	A framework which sets out the ethos of organisational learning and defines a suite of activities from ward to Board. Consideration of this then being amalgamated into the Clinical Governance Strategic Framework which is due for refresh this year and re-launch 25/26	Mar 25	GC+ALL	G&P

4.	**Legal Claims: Learning from and Improving Governance** • **Ensure that the outcomes from legal settlements and cases are used to inform further quality and safety improvements across our healthcare system**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**

4.1	Review of legal systems	Ensure learning from legal cases is shared back with clinical teams and bring learning from legal cases into Clinical Governance structures	Paper Jun 24	GC/JW	G&P

5.	**Pilot a systems quality improvement approach** • **Alignment of improvement activities to areas of organisational priority**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**
5.1	Quality Improvement Projects	• Use Deteriorating Patient Improvement Programme, learning from FAI and High Risk Medicines approach to develop a blue print for inclusion in the Learning Framework	Mar 25	**TM**	G&P

6.	**Creating Connections to Learn**				
	Improvement Activities	**Description**	**By When?**	**Lead**	**Governance/ People**
6.1	Creating Opportunities to Learn from themes of adverse events, complaints and legal claims	• Creating a bank of key words from SAERs, complaints and legal claims to help identify cross cutting themes	**TBC**	**CF and others TBC**	**G&P**

Appendix 2: Legal Claims: Learning from and Improving Governance Recommendations

	Recommendation
1.	**Notification**
1.1	When a legal claim is received the Chief Executive along with the relevant Director should be notified of the claim.
1.2	The Medical Director is currently notified of any clinical negligence claim and provided with any copies of associated complaints or adverse event reviews. This process should be extended to other Directors for non-clinical claims.
1.3	When the Legal Services Manager is notified of a scenario which may pose a potential legal exposure they will notify the relevant Director.
2.	**Learning from Claims**
2.1	When a legal case concludes or claim settles the Chief Executive and responsible Director should receive the advice report from CLO outlining rationale for settlement along with any expert reports provided. This should be shared with the relevant triumvirate leadership structure to review learning and identify any further improvement action that is required (giving consideration to improvement actions identified from the adverse event review). Any further action plans identified should be monitored through appropriate governance structures – mainly this will involve Clinical Governance.
3.	**Staff Support**
3.1	Develop a staff support package which provides information on support for staff who are involved in a legal claim
3.2	Staff involved should also be notified of the final outcome of the case in a supportive and reflective manner
4.	**Improving Governance**
4.1	Divisions to be provided with a quarterly report setting out all new and active claims including the nature of the claim in order to identify themes
4.2	All advice reports from CLO and any associated expert reports should be considered to assess if any further improvement action is required to mitigate a recurrence.

4.3	Assurance of actions relating to legal claims should be overseen through staff and clinical governance structures.
4.4	An appropriate timetable of reporting for legal claims needs to be agreed with the Staff Governance Committee and the Clinical Governance Committee (through the Clinical Governance Oversight Group). These reports should provide an outline of the themes of claims and any work underway to mitigate recurrence.
4.5	There is a requirement to develop a standard operating procedure which gives assurance with compliance of the 30 day timescale for subject access requests (aligned to GDPR requirements).
5.	**A Local Framework**
5.1	The output of this work should be a Legal Claims Framework which summarises processes, governance, how learning is shared and improvements monitored and provides guidance on staff support.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Deteriorating Patient Improvement Programme**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Gavin Simpson, Clinical Lead for Deteriorating Patients and Gemma Couser, Associate Director for Quality and Clinical Governance**

Executive Summary:

- Between 2015 and 2020 there was a sustained fall in the number of cardiac arrests across NHS Fife. In 2021/2022 the number of cardiac arrests increased. The assumption is that this increase in cardiac arrests was a result of the pandemic and may have been reflective of problems in detecting and managing deterioration for all patients- not just those who have a cardiac arrest.

- A programme of quality improvement work commenced in 2023 in response to this change. The focus of the improvement work is alignment of our systems and processes to Care of Deteriorating Patients and SIGN 167. Early identification and appropriate intervention for deteriorating patients reduces the risk of adverse outcomes such as preventable cardiac arrest. Failure to implement effective systems results in increased mortality and morbidity.

- Data for 2023 shows promise with a decrease in the number of cardiac arrests. It is too early to say if the improvement work will deliver a sustained improvement and if this is a shifting trend. Continued focus is required on system process measures including; patient observations taken on time, compliance with the structured response, completion of hospital anticipatory care plans and do not attempt cardiopulmonary resuscitation documents.

- It should be noted that NHS Fife have a mature and systematic process in place to review every cardiac arrest, meaning that every unexpected death is reviewed. Learning and themes from reviews are collated and an improvement plan is implemented.

- This paper is brought to the Clinical Governance Committee to provide a moderate level of assurance and to recommend that this improvement programme is supported for the remainder of 24/25 and into 25/26.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board Strategic Priorities :
  - Improve the quality of health care services
  - Improve health and wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Between 2015 and 2020 there was a sustained fall in the number of cardiac arrests across NHS Fife. In 2021/2022 the number of cardiac arrests increased. This paper sets out the Deteriorating Patient Improvement Programme that was initiated in response to this change including:

- The approach to the improvement programme
- Focused improvement work undertaken so far
- Governance and Learning
- Next steps

The aim of the improvement work is to reduce cardiac arrests in the Acute Services Division and Health and Social Care Partnership by March 2025 by improved communication and escalation in line with SIGN 167. Delivering:

- 90% of observations on time
- 90% compliance with hospital anticipatory care plans (HACP) and do not attempt cardiopulmonary resuscitation (DNACPR)
- 90% structured response use with high early warning scores

2.2 Background

Deteriorating Patients are at risk of cardiac arrest. The mortality rate from in hospital cardiac arrest is high. After 5 years of a sustained fall in the number of cardiac arrests

in NHS Fife after the introduction of the Know the Score Programme in 2015, the number of cardiac arrests started to increase in 2021 (shown in Chart 1 below).

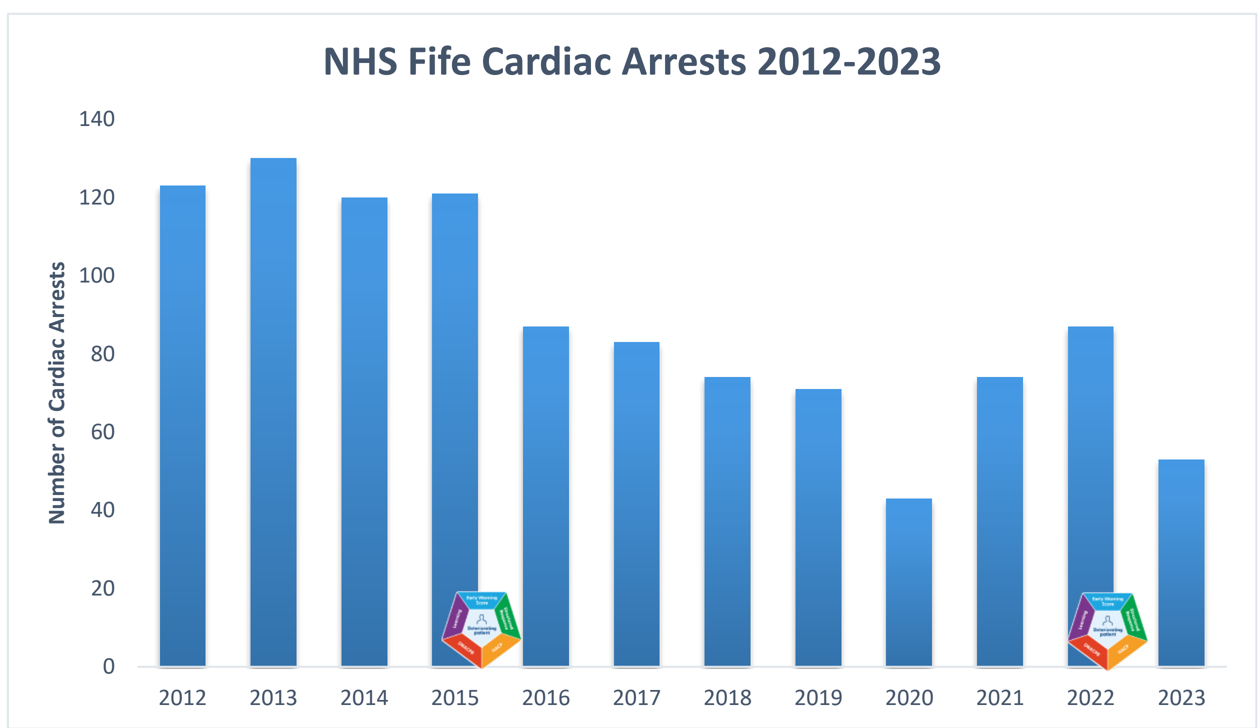


Chart 1: Number of Cardiac Arrests in NHS Fife 2012-2023

The increase in cardiac arrests was correlated with the pandemic and may have been reflective of problems in detecting and managing deterioration for all patients- not just those who have a cardiac arrest. When this change was identified an improvement programme was initiated to understand system problems across Acute Services and the Health and Social Care Partnership in order to identify relevant improvement actions. This improvement work has been supported by the Corporate Project Management Office (CPMO) and the Quality and Clinical Governance (Q&CG) teams.

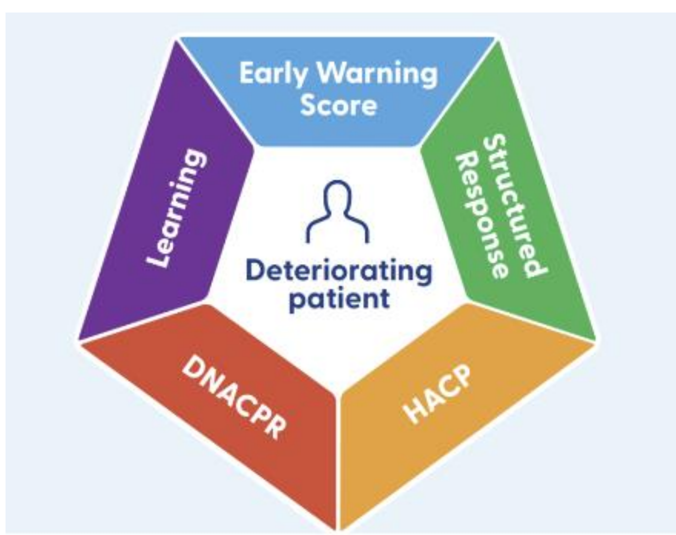
Scottish Intercollegiate Guidelines Network (SIGN)

Guidelines for the Care of Deteriorating Patients is set out in SIGN 167. This guidance published in 2023 covers:

i. Planning and Decision Making
ii. Recognition of Deterioration
iii. Early Warning Scores
iv. Sepsis
v. Response to Deterioration
vi. Handover Communication

Know the Score

‘Know the Score’ is a framework created in 2015 with the aim to prevent avoidable cardiac arrests by identifying, treating and escalating deteriorating patients rapidly to make hospital a safer place for patients. The framework is made up of 5 key elements for patient safety these are - Early Warning Score, Structured Response Sticker, Hospital Anticipatory Care Plan (HACP), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Learning. Know the Score framework is currently being re-launched across NHS Fife. There is ongoing work to adapt Know the Score for use in community settings.



By identifying, treating and escalating deteriorating patients rapidly avoidable cardiac arrests can be prevented. By making decisions earlier, using HACP and DNACPR, ineffective and traumatic treatments can be avoided, including Cardiopulmonary Resuscitation (CPR), when they will not be successful.

Review and Learning from Cardiac Arrests
NHS Fife Quarterly Deteriorating Patient Report details the cardiac arrest that have been reviewed throughout the year. Reviews are done for every single cardiac arrest. This allows themes to be gathered, analysed and fed back into the governance structures and clinical teams involved in the cardiac arrest/ care of patient. This means in NHS Fife all unexpected deaths are investigated.

2.3 Assessment

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

Progress to Date

The following section sets out some of the key work undertaken across structured response, DNACPR, HACP, training/education, communication, digital & information and Learning.

Structured Response

- Focus on compliance with structured response stickers
- Weekly compliance audits carried out
- Know the score boxes tested in ward 44 then rolled out to all acute ward containing stickers and completed examples of forms
- HSCP have implemented new structured response stickers in line with Know the Score
- Implementation of new "Know the score" resource packs across HSCP

DNACPR

- Monthly auditing of patient forms on wards
- Quarterly reporting of audit results
- Know the score boxes tested in ward 44 and rolled out to all acute wards

HACP

- Monthly auditing of the patient forms on wards
- Quarterly reporting of audit results
- Know the score boxes
- Improving compliance on HACP and DNACPR forms with data collection in HSCP

Training

- Bespoke teaching sessions were completed in February 2024 for all new training doctors, nursing staff and allied health professionals to raise awareness of completing observations on time and the use of the Fife Early Warning Score.
- Know the Score Training is being delivered by our advanced nurse practitioner to staff on their wards
- The Resuscitation Team have updated the Know the Score training materials using a case study which has had good engagement

Communication

A communications plan has been developed to promote Know the Score and deteriorating patient improvement work across the organisation.

Digital and Information Solutions

Testing of Welch Allyn monitors (supporting e-observations) commenced in Wards 43 and 44 on 9th July 2024.

Improving Learning from Cardiac Arrests

A Cardiac Arrest flash card January – June 2024 has been developed to share outcomes of cardiac arrest reviews with staff and support learning. The flash report sets out areas of good practice and areas for improvement further to cardiac arrest reviews:
Good practice noted following cardiac arrest reviews

- Prompt/timely recognition of deterioration
- Clear evidence of senior review
- Observations completed on time
- SR Sticker used correctly and hourly observations completed as appropriate
- Clearly noted plan and ceiling of care documented in notes

Areas of improvement identified from cardiac arrest reviews

- Use of Structured Response (SR) sticker when a patient has an Early Warning Score (EWS) of 3 or more
- Admission document for escalation status has not been completed fully
- Earlier decision regarding DNACPR
- Better fluid balance chart documentation
- Observations not obtained after 60 minutes when patient FEWS 4

Treatment Escalation Plan

New National Treatment Escalation Plan (TEP) documentation has been shared with the Deteriorating Patient Planning Group. Support to test the new form in the orthopaedic trauma wards has been agreed. Timings for testing will be reported in due course.

Improvement Impact

The improvement focus is starting to indiciate an impact. Within ASD a positive trend is emerging with the compliance with observations taken on time (chart 2 below). A more significant improvement is being observed with compliance with the structured response (chart 3 below).

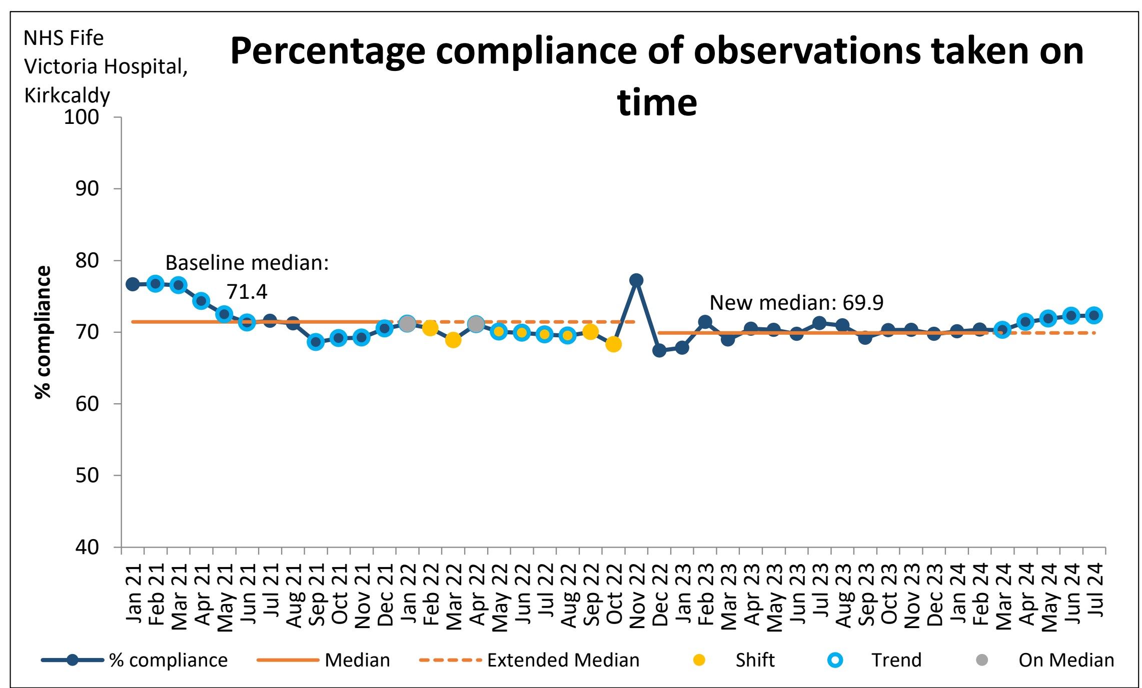


Chart 2: Percentage Compliance of Observations Taken on Time, ASD, Jan 21- Jul 24

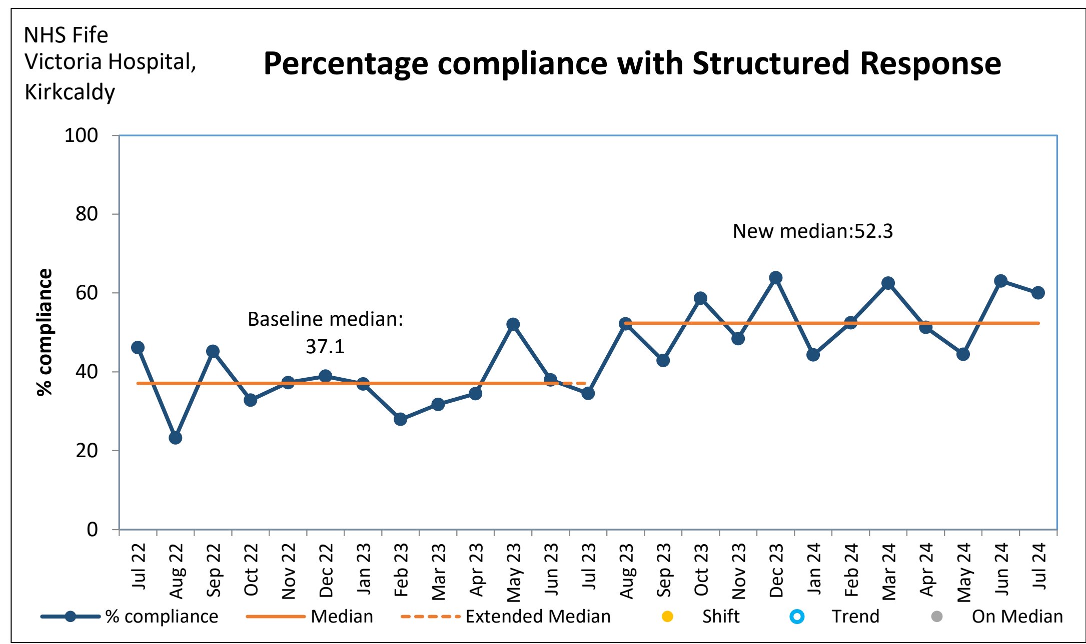


Chart 3: Percentage Complaince with Structured Response, ASD, Jul 22- Jul 24

Improvement Focus in Assessment Area 1 (AU1)

AU1 was identified as a priority area due to the high number of patients and high level of acuity. Focused improvement work supported by the CPMO and Q&CG team started early in 2024. This work has included:

- Focused training to ensure all staff are trained using structured response pocket cards
- Know the score Board now visible in the AU1 corridor

- Weekly audits to measure compliance with observations taken on time and structured response
- Meeting with key staff to understand barriers to the completion of HACP and DNACPR documentation
- Focus on compliance with Structured Response Stickers
- Weekly reporting to AU1 to monitor improvement
- Know the Score boxes tested in ward 44 then rolled out to all acute wards containing stickers and completed examples of the forms

Chart 4 below shows a positive shift in compliance with the structured response in AU1 since this improvement work commenced. Compliance with observations on time has remained largely static since the improvement work commenced and further investigation is required to determine opportunities for improvement.

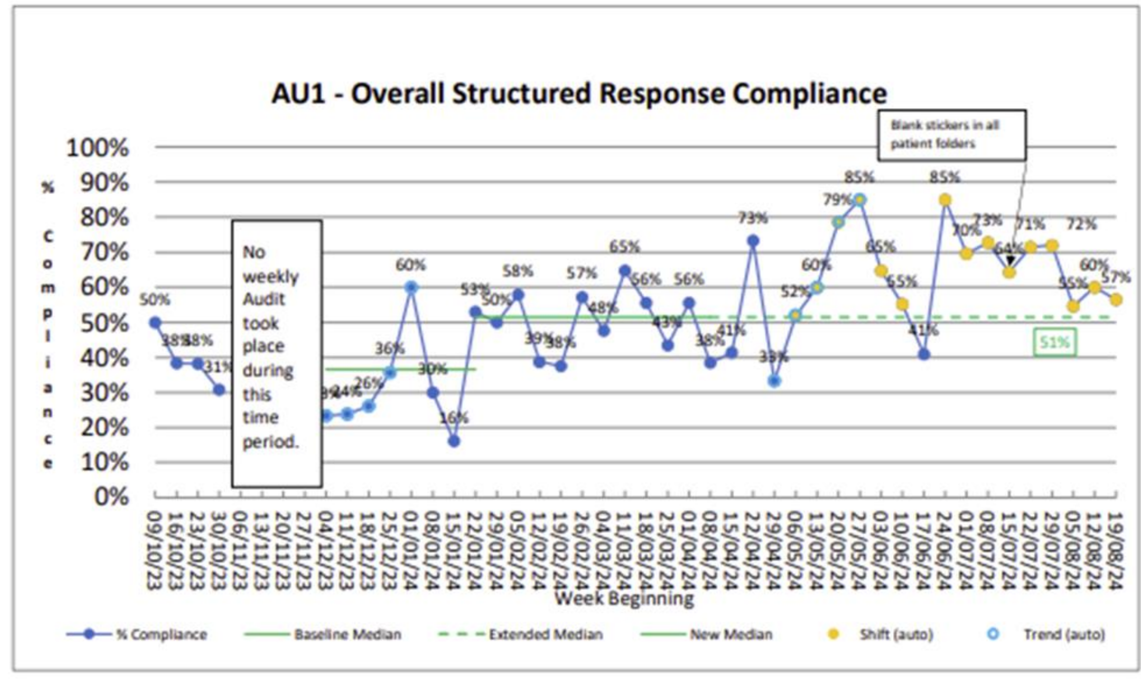


Chart 4: AU1 Overall Structured Response Compliance Oct 23- Aug 24

REFRESHING THE IMPROVEMENT PLAN

SIGN 167 Benchmarking Questionnaire

To determine the compliance with SIGN 167 across ASD and HSCP a benchmarking questionnaire was completed by Senior Charge Nurses with 100% returned from HSCP and 84% returned from ASD. It is understood that NHS Fife is the first Board in Scotland to undertake such a detailed assessment and this work is supporting focus of improvement planning for the next 12 months. Key areas requiring further invesgitagion from this questionnaire include:

Patientrack

- D&I training including changing frequency and parameters

- Patientrack screen on display in ward to track observations on time, patient acuity and important key information

Handover

- Just over half of the people who completed the questionnaire from ASD wards said there is a formal checklist or structure in place for patient handovers. Guidance recommends that formal checklists should be considered for handovers, to avoid variability and improve essential communication.

Management of Deterioration

- The deteriorating patient escalation pathway needs to be displayed clearly across all inpatient ward areas. 68% answered yes from ASD wards. 59% answered yes from HSCP wards
- The use of the structured response sticker is new to HSCP with only 38% of people confirming they use it
- The Know the Score boxes are not being used within all the wards who have them
- There is a lack of structured handover of individual patients who are deteriorating in a number of wards across ASD and HSCP with no formal checklist

Care Planning

- There are challenges across NHS Fife to get HACP/ MyACP forms completed for patients who require this with less than half finding the forms straight forward to get completed
- There are challenges across NHS Fife relating to DNACPR form completion for those who require them

Sharing and Communicating

- There are a lack of display boards across NHS Fife to allow staff to see important information relating to Know the Score principles. Clear feedback of standards and performance drives improvement.

Deteriorating Patient Workshop

The feedback from the questionnaire above and the most recent Deteriorating Patient Workshop held in August is supporting a refresh of the improvement focus. Work is underway to theme the feedback from the Deteriorating Patient Workshop held in August 2024 (draft report contained in appendix1). The clinical teams who attended signalled the following high level areas need to be a focus for the next 12 months:

Processes:

- Communication and safe handover
- Whole system approach to care planning

Digital and Information

- e-observations (Welch Allyn pilot) roll out- remove human factors

Structured Response

- When to complete
- Escalation and out of hours management

Training and Education

- Multi-professional training
- Documentation
- DNA-CPR training

Improvement Driver Diagram

An improvement driver diagram has been developed to guide the improvement focus and achieve the aim (appendix 2). This will also be reviewed in light of the most recent workshop.

It is anticipated that a refreshed improvement plan will be finalised in September 2024.

2.3.1 Quality, Patient and Value-Based Health & Care

Early identification and appropriate intervention for deteriorating patients reduces the risk of adverse outcomes such as preventable cardiac arrest. Failure to implement effective systems results in increased mortality and morbidity. This work is fundamental to ensuring high quality care is delivered to patients.

2.3.2 Workforce

Engaging with multi-professional clinical teams is fundamental to this success of this work.

2.3.3 Financial

The aim of this work is to improve the quality and safety of care delivered which in turn should have a positive impact on efficiency.

2.3.4 Risk Assessment / Management

The improvement programme aims to reduce the risk of mortality and morbidity through effective identification and management of deteriorating patients.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The content of this paper is derived from the work of the Deteriorating Patient Project Group which includes:

Deteriorating Patient Clinical Lead
Clinical Effectiveness Manager
Associate Director for Quality and Clinical Governance
Clinical Effectiveness Team Leader
Portfolio Manager (for Quality Improvement)
Deteriorating Patient and Resuscitation Lead
Clinical &Care Governance Support Facilitator
Head of Digital Delivery (from August)
Senior Project Manager, Digital and Information (from August)
Programme Manager, Digital and Information (from August)
Head of Nursing, HSCP
Clinical Development Nurse, HSCP
(With ad-hoc attendance from key clinical stakeholders involved in some of the areas of improvement focus)

In addition regular meetings have taken place with the Nurse Director, ASD and Deputy Medical Director, ASD.

Continuing to connecting and involve clinical teams is fundamental to this work. Following the most recent workshop there is work underway to determine how best this is achieved.

2.3.8 Route to the Meeting

The contents of this paper have been presented to the Clinical Governance Oversight Group for assurance. The group was supportive of the continued focus on delivering this work.

- Clinical Governance Oversight Group, June 2024
- Clinical Governance Oversight Group, August 2024

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

This paper is also provided for **decision** - to support the continued focus on this work for the remainder of 2024/25 and for 2025/26.

3 List of appendices

- Appendix 1 - Draft Deteriorating Patient Workshop Summary August 2024
- Appendix 2 - Deteriorating Patient Improvement Programme Driver Diagram

Report Contacts

Gemma Couser
Associate Director for Quality
and Clinical Governance
Email gemma.couser2@nhs.scot

Gavin Simpson
Deteriorating Patient Clinical Lead
Email gavin.simpson@nhs.scot

Appendix 1: Draft Deteriorating Patient Workshop Summary August 2024

Deteriorating patient

Know the score

By identifying, treating and escalating deteriorating patients rapidly, we can prevent avoidable cardiac arrests.

Scan the QR code or visit the 'Deteriorating Patients' StaffLink pages to learn more about avoidable cardiac arrests and the 5 key elements of patient safety.

Overview:

A Deteriorating Patient Workshop was held on 23 August 2023 to explore how we can improve the care of deteriorating patients across all inpatient settings in NHS Fife. Since this workshop, a lot of improvement work has been ongoing across NHS Fife including Health & Social Care Partnership wards, AU1, Ward 43 and Ward 44 in Victoria Hospital. A Deteriorating Patient Benchmarking Survey was sent to all Senior Charge Nurses across NHS Fife inpatient areas in March 2024 to assess how we provide care for our Deteriorating Patients. This was designed to assess our performance compared to the recently published SIGN 167 guidelines. Responses were received from 75% of NHS Fife inpatient ward areas.

A further workshop was held on 21 August 2024 to discuss the results of the survey. The feedback from this event will assist with the development of the Deteriorating Patient work plan for the next 12 months across all areas of NHS Fife.

Workshop aims:

The workshop sought to:

- Develop the Deteriorating Patient improvement plan for the next 12 months
- Share SIGN 167 Benchmarking Questionnaire Results
- Discuss Improvement Driver Diagram
- Agree next steps

Who Attended:

The event was chaired by Gemma Couser, Associate Director of Quality & Clinical Governance and Dr Gavin Simpson, Chair of NHS Fife Deteriorating Patient Group, and was attended by around 30 members of the multi-disciplinary staff from across NHS Fife.

Who Presented:

- Gemma Couser gave an overview of the workshop aims and expressed the importance of receiving feedback from the attendees to assist with the improvement plan.
- Gavin Simpson presented on the Deteriorating Patient work that has been done over the last year and how NHS Fife is performing.
- Tom McCarthy-Wilson, Portfolio Manager, Corporate Project Management Office presented the Deteriorating Patient Driver Diagram.
- A facilitator from each of the 5 groups presented feedback from each of the questions which is detailed on page 2.

Contributory factors to cardiac arrests:

- 33% of cardiac arrest cases have problems with communication
- 11% of cardiac arrests - identified problems with the patient delivery of care
- 20-40% of cardiac arrest patients should have had a DNA-CPR in place prior to their cardiac arrest

Group Discussion Question 1: What are your reflections on the information presented – how does this compare to your experience?

1. **Communication**
Participants highlighted the need for better communication between ward teams and other departments.
2. **Documentation**
The groups indicated that further training would be beneficial around discussing and completing the Hospital Anticipatory Care Plan.
3. **Processes**
It was highlighted that it would be beneficial to share best practice to ensure ward areas are following the same processes for deteriorating patients.
4. **Training & Education**
Several key areas were highlighted around training and education to ensure that staff have the appropriate knowledge.
5. **IT**
Digital enablement was discussed including system access, system knowledge and access to digital patient information.

Group Discussion Question 2: What do you consider to be the top three priorities for improvement over the next 6-12 months?

Four priorities emerged from the feedback provided:

1. **Processes**
- Escalation Process
- Communication and safe handover
- Ensure correct/ relevant information is shared to all departments
- Escort Policy/ Communication between departments/ Patient transfer
- Whole system approach to care planning

2. **IT**
- E-observations
- Welch Allyn – reduce reliance on human factors
- Connectivity between systems
- Key forms easy to access on portal

3. **Structured Response**
- When to complete
- Escalation
- Overnight management
- Systems

4. **Training & Education**
- IT systems
- Documentation
- Escalation
- Awareness
- Identify education need
- Prioritise deteriorating patient training
- NEWS2/ MEWS
- Mandatory training
- Funded time to backfill/ study leave to avoid staff cancelling sessions
- Face 2 face training (online learning might not happen/impact)
- Training in wards
- Bite size sessions
- Training for clinical management of deteriorating patients
- Multi-professional Teaching
- DNACPR training for medical/ nursing teams

Group Discussion Question 3: Considering the priorities you have identified what are the solutions and enablers to implement improvements?

1. **Communication**
- Delivering Information
- Information sharing
- Digital representation on Deteriorating Groups
- Communication with the right teams
- Involving clinical teams on the floor
- Involved in practice in promoting improvements/ change
- Ask team about barriers
- Managing patient/ family expectations
- Realistic medicine
- Scope current resources
- Data - ensure what we are doing with it is relevant to wards
- Ward of the week
- Deteriorating patient HOT team to visit ward

2. **IT**
- Ensure enough IT equipment
- Ensure IT works
- Speeding up log-in process (e.g. tap on/off with badge)
- Resus/DNACPR completion data – SCN might know but do all staff on ward
- RESPECT in place of KIS so can be kept up to date
- Welch Allyn access
- SR on Patientrack

3. **Training & Education**
- IT systems
- DNACPR currently seen as medical discussion - Train and empower others
- Freeing people up for education
- Face to face training
- Access to simulation
- Accredited training
- Digital drop ins
- Workshops
- Multidisciplinary (need to ensure inclusive – medics often absent)
- Reinvigorate protected learning time
- Make up a SIM, be creative with resources including Know the Score boxes
- Evaluate improvement
- Building confidence and trust in new systems/process
- Ownership locally - Involve staff in ward areas in developing change in SBAR

What Participants said about the Workshop?

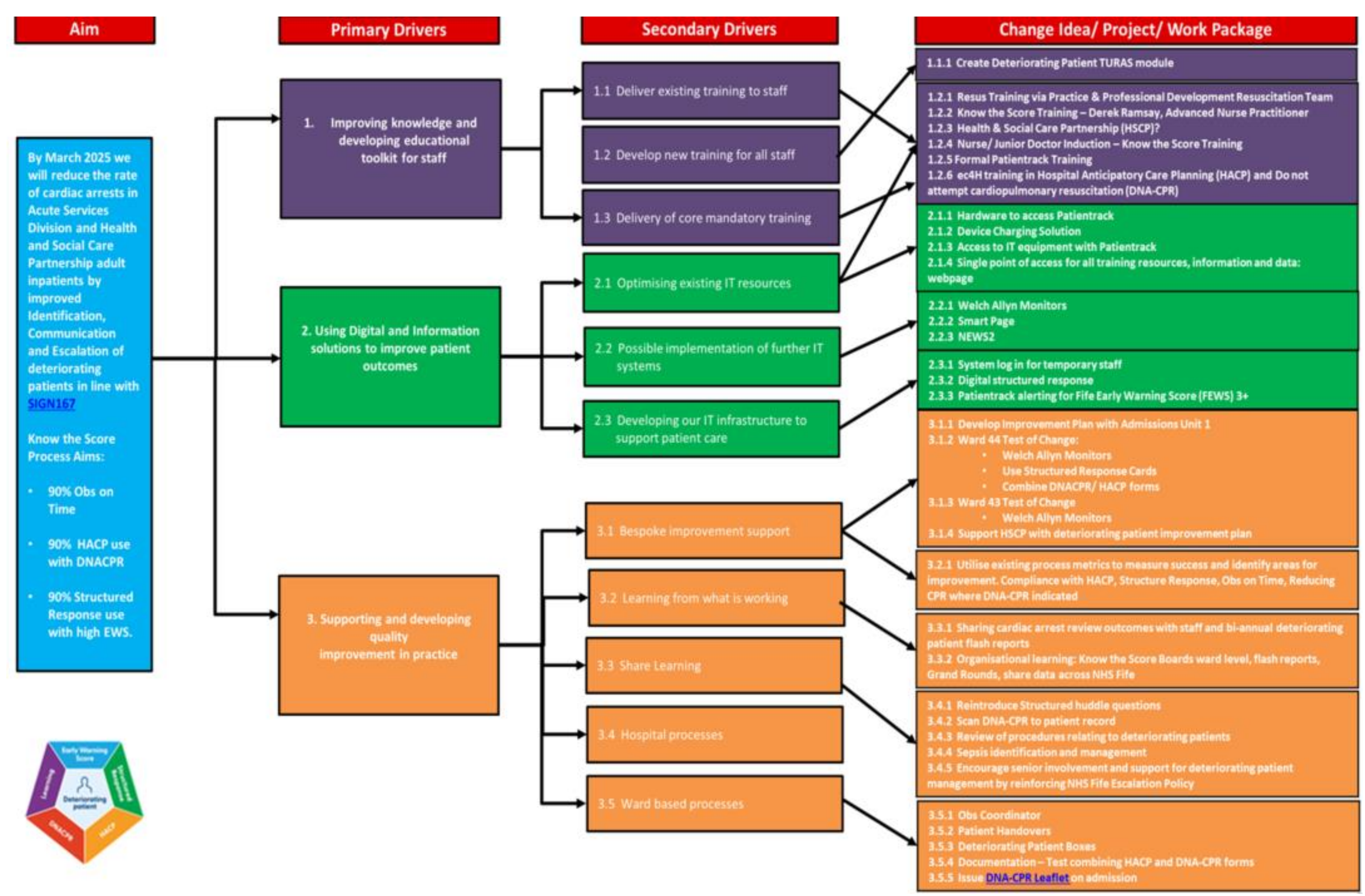
- Good to have multiple specialities represented. Groups well put together to allow shared experiences
- Excellent workshop. Would have been good to look at what's already underway in relation to the challenges
- Well organised event, good to meet people face to face rather than via email
- Key stakeholders were present or represented
- Would be good to involve patients and family representatives

Next Steps

- We will develop a deteriorating patient improvement plan for the next 12 months and share with all clinical staff across NHS Fife
- We will work with clinical teams to help them make changes that improves the care of deteriorating patients

Contact NHS Fife QI Network if you have any questions:
fife.qinetwork@nhs.scot

Appendix 2: Deteriorating Patient Improvement Programme Driver Diagram



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Neonatal Mortality Review Health Improvement Scotland Report (HIS)**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Aileen Lawrie, Director of Midwifery**

Executive Summary:

Public Health Scotland (PHS) data showed an increase in neonatal mortality in Scotland in September 2021 and March 2022. This breached PHS statistical control limits.

On 17 August 2022, the Minister for Public Health, Women's Health and Sport commissioned HIS to take forward the review in response to this significant increase in neonatal mortality. The review covered reported neonatal deaths across Scotland between 1 April 2021 and 31 March 2022.

1 Purpose

This report is presented for:
- Assurance

This report relates to:
- National Health & Wellbeing Outcomes.
- NHS Board Strategic Priorities to Improve Health & Wellbeing and to Improve Quality of Health & Care Services.

This report aligns to the following NHS Scotland quality ambition(s):
- Safe.
- Effective.

2 Report summary

2.1 Situation

There had been concerns raised by the WCCS Directorate via EDG in December 2021 regarding local data that demonstrated an increase in the number of term babies (greater than 36 weeks gestation) who had an adverse outcome over the preceding 10 months. There was a requirement to identify if there were any continuing common themes or an issue in the clinical care course of these women and babies that required being actioned to reduce risk of recurrence. A further

paper was submitted to EDG on 5 May 2022. Following this the National External Review of cases was undertaken.

2.2 Background

This increase in poor outcomes locally was evident across 3 categories:

- **unexpected neonatal death,**
- **requirement for therapeutic hypothermia (cooling) treatment (TC) for hypoxic brain injury,**
- **significant neonatal brain injury.**

2.3 Assessment

The main findings of the National review were as follows:

- There was a significant increase in neonatal mortality in Scotland in 2021/22. The number of additional neonatal deaths in Scotland in 2021/22 compared to the previous 4 years is estimated at 30. UK-wide data describes an increase in neonatal mortality across all 4 devolved nations for those babies born after 24 weeks' gestation in 2021. In 2022/23, the neonatal mortality rate in Scotland returned to that observed between 2015 and 2020. Data from January to September 2023 suggests a return to higher neonatal mortality rates.

- More babies than expected were born before 28 weeks' gestation in Scotland in 2021/22. Since babies born before 28 weeks' gestation have a higher neonatal mortality rate than babies born later in pregnancy, their gestation contributed to the overall increase in neonatal deaths in Scotland in 2021/22.

- There was a significant increase in the neonatal mortality rate for babies born at 32-36 weeks' gestation in Scotland in 2021/22. Of the 25 babies born at 32-36 weeks' gestation 10 had a congenital condition incompatible with survival and a further 3 had either a major congenital or a genetic condition that contributed to their deaths. From the data available, the review team were unable to determine if this reflected a change in the incidence of congenital conditions, or a change in the management of babies affected by major congenital conditions, and/or how much of the increase in neonatal mortality for babies born at 32-36 weeks' gestation in 2021/22 could be attributed to congenital conditions.

- The registered causes of neonatal deaths in Scotland in 2021/22 were broadly similar to those in previous years, with no new or unusual causes of death identified. Data suggests a possible higher rate of labour and delivery problems but this does not explain in full the increase in neonatal mortality in 2021/22.

- There was almost twice the number of neonatal deaths in babies born of multiple births than would have been anticipated. This increase would have contributed to the increased neonatal mortality rate in 2021/22 and is likely associated with the higher proportion of multiple births that were very preterm.

- It was not possible to draw any conclusions regarding the impact of ethnicity on neonatal mortality in 2021/22, due to insufficient recording of maternal ethnicity.

- There was significant variation in the quality of local review reports into neonatal deaths in Scotland submitted by NHS boards for the purpose of this review, which is

likely to have resulted in missed opportunities for learning. This limited the conclusions that could be reached by the Review Panel. As only local review reports for 2021/22 were considered, it is not possible to comment on how these reports compared with preceding years.

- From the information available in the local review reports the Inspection did not find evidence of systemic failures of maternity or neonatal care either across Scotland as a whole, or in any one NHS board, that would account for the significant increase in neonatal deaths in 2021/22. Nor did they identify either unusual factors or a cluster of any one factor to explain the increase in neonatal deaths in this period. Without comparative data from preceding years they could not determine how many neonatal deaths in 2021/22 were potentially preventable.

- Whilst it is possible that the direct and indirect effects of the COVID-19 pandemic may have contributed, at least in part, to the increase in neonatal mortality in Scotland 2021/22, it is not possible to draw conclusions about this from the information available in this review.

- Only one NHS board had a stabilised and adjusted neonatal mortality rate, 5% or more higher than similar neonatal units across the UK. This was NHS Fife. In 2021/22 there were 13 neonatal deaths in NHS Fife, which equates to one death more than would have been anticipated.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s) but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk.

2.3.1 Quality, Patient and Value-Based Health & Care

NHS Fife was asked by the external review team for assurance regarding the quality of reviews undertaken for a small number of the Fife cases (due to confidentiality the number cannot be shared) and that outcome grading and learning from the reviews were accurate. One of the cases had already had the grading and learning changed by the local team and there is one further case still in the process of re review for assurance.

2.3.2 Workforce

Staff were offered support as part of usual process through the clinical reviews, the external review period and following publication of the report.

2.3.3 Financial

At this time there is no financial consequence from the findings of the external review.

2.3.4 Risk Assessment/Management

The National Review highlights that there has been no failing in care from any Board. Locally we continue to undertake maternal and neonatal reviews following National guidance.

2.3.5 Equality and Human Rights, including Children's Rights, Health Inequalities and Anchor Institution Ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, Involvement, Engagement and Consultation

All families who were subject to care review were consulted as part of the process and have had the opportunity to input into the review of their, and/or their child's, care. All have received the reviews reports and had further opportunities to discuss the individual findings.

2.3.8 Route to the Meeting

Executive Directors' Group.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

- Appendix 1 Neonatal Mortality Report – can be found at this link: HIS Neonatal Mortality Report

Report Contact:
Aileen Lawrie
Director Of Midwifery
Email aileen.lawrie@nhs.scot

NHS Fife

Meeting: Clinical Governance Committee

Meeting date: 6 September 2024

Title: Digital and Information Strategy 2019-24 Update

Responsible Executive: Alistair Graham, Director of Digital and Information

Report Author: Alistair Graham, Director of Digital and Information

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- NHS Fife Corporate Objectives

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Fife's Digital and Information Strategy "Digital at the Heart of Delivery" was endorsed by the NHS Fife Board in September 2020 and was intended to operate from 2019 – 2024. The strategy outlined the opportunity and challenge which had been presented to NHS Fife from a National, Local and Regional perspective through various digital and data strategies and delivery plans.

Throughout the period, the Digital Strategy, has undergo continuous review and more recently alignment to NHS Fife's Population Health and Wellbeing Strategy (2023-2028).

Work commenced on the preparation of a revised Digital Strategy, however, a number of factors influenced the ability to progress the development of a future focussed and fully formed Digital Strategy. These items are outlined in Section 2.2.

The paper seeks to outline the approach to develop a Digital Framework that is orientated around the key priorities of the Re-form, Perform and Transform framework, the Medium-Term Financial Plan, direct alignment to Corporate Objectives 2024-25 and the Population Health and Wellbeing Strategy.

The approach outlined and current progress is presented for assurance.

2.2 Background

The Digital Strategy 2019 – 2024 outlined the 5 key ambitions for Digital and Information: -

- Modernising Patient Delivery – Ensuring we provide our patient/service users with a modern fit for purpose digital healthcare service.
- Joined Up Care – Joining Up Our Services to ensure all relevant information is available at point of contact.
- Information and Informatics – Exploiting data to improve patient safety and quality outcomes to support developments.
- Technical Infrastructure – Ensuring the infrastructure on which digital is situated is fit for purpose, secure and meets the needs of our service.
- Workforce and Business Systems – Assisting our workforce by ensuring the systems on which they operate are effective, efficient and compliment their working practices.

Progress on the strategy implementation continues to be reported to the Clinical Governance Committee (CGC) twice a year. With a full review of the 49 associated deliverables being presented to CGC in November 2023.

As the development of a revised strategy began, several factors were identified at a national level, many of which will have a significant bearing on a strategic outcome for Digital and Information. The main areas identify include: -

- The signalling of a refresh to the national Digital Health and Care Strategy that was published in 2018.
- The development of revised governance arrangements, yet to be fully established for Digital and Data within Scottish Government.
- Review of existing delivery models for digital capability at a national and regional level being conducted by a Board Chief Executive who has Digital within their portfolio.
- Consideration of the existing contract arrangement for the National Patient Management System. This contract is due to expire in 2029, with an assessment on preferred options expected during the remainder of 2024/25.
- Presentation of plans to progress a national Digital Front Door and approach to an integrated health and care record.
- The scale of the current financial challenge.

- The development of the Re-Form, Transform and Perform Framework (RTP).

2.3 Assessment

Given the degree of change outlined in the national arena for Digital and Data and the need to support the requirements of NHS Fife's RTP Framework, it has been agreed by the Digital and Information and through the Corporate Objectives, that a Digital Framework is developed rather than an overarching multiyear Digital Strategy.

In doing so the framework would provide time for the factors outlined in Section 2.2 to be resolved or progressed, have direct alignment to the schemes within the RTP and take less time to produce.

Alignment to RTP will be a key element of the framework, with links and plans being associated with existing schemes and the emerging CHOICES submission.

The other themes within the framework will include:-

- Continued development of the Electronic Health Record (E.H.R.) and additional data sharing to ensure it becomes part of an Integrated Care Record available to all that provide care to our patients. The E.H.R. Steering group ensuring that the removal of paper and support to efficient working methods is a focus.

- Continued development of the digital front door, allowing our patients to have access to and the ability to access their paperwork digitally and contribute to their own health record, a function that will further reduce our reliance on paper and maximise our clinical capacity.

- Continued implementation of our Digital Medicines programme.

- To develop our capability to maximise the capacity for consultation and treatment, including the ability to continually monitor the patients who are waiting.

- To support our staff in their work by reducing the number of systems they operate, leveraging integration, improve their available time through automation and be ready for the implementation of artificial intelligence.

- Ensure our business systems become an enabler to ensure the correct compliments of staff, with the correct skills are available in the right work setting, while being considered of financial impact and support the wider governance of NHS Fife.

- Continue to provide insight through the availability and analysis of data to support operational decision making and strategic planning.

- Ensure our infrastructure receives continual investment to guarantee its availability, performance, security, and capacity.

- Support our compliance and legislative activities in support of our Privacy Programme and Cyber Resilience Framework.

- Deliver an operating model that remains agile to emerging need and innovation yet can sustain large programmes and demand for digital change.

- Underpin the framework through details of resource models and financial plans.

The framework will be made available to the Digital and Information Board October 2024 meeting along with a proposal for wider consultation and governance.

Progress with the Digital and Information Annual Delivery Plan continues. The Quarter 1 update for 2024-25 is included in Appendix 1.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

The aims which were clearly outlined in the Digital Strategy 2019/24 focussed on the ambitions laid out in several key strategies and plans at a local, regional, and national level. The requests for support focus mainly on the use of technology to support improvements in quality and patient care, and to this end it is apparent the deliverables which were outlined in 2019 remain central to supporting quality and patient care.

As we embrace value-based Health Care, increased demands are expected, particularly when allowing patients to contribute to their health and care plans.

2.3.2 Workforce

As we progressed through the strategy, the Digital and Information workforce plan, supported by the national strategic fund was able to tackle the underlying issue of temporary and fixed term roles. The availability of suitable levels of resource to match the demand is under threat as we experience increased levels of turnaround during the 1st Quarter of 2023-24.

As we consider the elements of RTP, we also consider the work necessary to ensure our wider workforce can feel supported in their digital adoption. We will work closely with colleagues in Partnership and Workforce to ensure this support is well designed and impactful for staff.

2.3.3 Financial

The scale of the demand and the financial impact associated continues to be a risk that is managed. Digital and Information continue to work closely with Finance and Clinical colleagues to establish the prioritisation of work to ensure maximum return on investment is achieved. Several Cost Improvement Plans have been provided in support of the core saving required as D&I commitment to the Corporate scheme total. The scale of demand for digital solutions does not match the available funding or resourcing and so ranking is a key requirement for all initiatives.

2.3.4 Risk Assessment / Management

The risk management approach continues to be maintained via the Corporate Risk Register, with additional risk reporting and presentation being provided to the Digital and Information Board.

A formal risk appetite and tolerance statement has been agreed by the Digital and Information Board allowing a refreshed reporting of Risk controls and mitigations.

The work associated with the creation of the revised Digital Framework is a key action with the mitigation of the Corporate Risk 18 – Digital and Information.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) is completed for all new systems and technology changes. In many cases these identify the requirement for full EQIAs to be prepared and considered as part of the project implementation.

2.3.6 Climate Emergency & Sustainability Impact

Consideration of the Scottish Public Sector Green ICT Strategy forms part of the revised strategic thinking.

2.3.7 Communication, involvement, engagement and consultation

Engagement activities continue to inform the approach and prioritisation for implementation of digital capabilities.

2.3.8 Route to the Meeting

This paper was previously considered by the Digital and Information Board, 23 July 2024.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

- Appendix 1 – Digital and Information Annual Delivery Plan Update - Quarter 1

Report Contact
Alistair Graham
Director of Digital and Information
Email: alistair.graham1@nhs.scot

Appendix 1 - Digital and Information Annual Delivery Plan Update - Quarter 1

Deliverable	Outcome	NHS Board Deliverable Reference	Recovery Driver	ADP Reference	End	Deliverable 24/25 Q1 RAG Status
National & Local Priority - Hospital Electronic Prescribing and Medicines Administration (HEPMA)	Implementation of Stock Control system Implementation of IDL Implementation Commence HEPMA implementation	FIF-DIGI-04	9. Digital & Innovation	9.1	Mar-26	Amber - At risk - requires action
National - Child Health Replacement	Support requirements gathering Preparation for business change Implementation of Child Health System	FIF-DIGI-06	9. Digital & Innovation	9.1	Mar-25	Amber - At risk - requires action
National - eRostering	Implementation of eRostering products to Service Areas as per deployment plan Implementation of Interfacing to other Business Systems	FIF-DIGI-07	9. Digital & Innovation	9.1	Nov-25	Amber - At risk - requires action
National - GP IT Reprovisioning - GP Sustainability	Procurement of GP IT System	FIF-DIGI-08	9. Digital & Innovation	9.1	Mar-26	Amber - At risk - requires action
National - LIMS Implementation	Implementation of National MagentusProduct Enhancements to Magentus Product	FIF-DIGI-09	9. Digital & Innovation	9.1	Mar-25	Amber - At risk - requires action
Business Transformation - RTP	Reduction in Paper Use Amnesty for EndPoint Devices Contract Reviews System Replacement/Decommission	New	9. Digital & Innovation	9.3	Mar-25	Green - On Track
Infrastructure - Workforce	Workforce Validation Exercise	New	9. Digital & Innovation	9.3	Mar-25	Green - On Track
Local - Implement Electronic Health Record	Alignment to RTP Reduction in the use/reliance on paper Scanning function adopted by multiple services. Governance approach adopted for digitisation of clinical process and availability of data to patients/carers	FIF-DIGI-10	9. Digital & Innovation	9.6	Mar-25	Green - On Track

Deliverable	Outcome	NHS Board Deliverable Reference	Recovery Driver	ADP Reference	End	Deliverable 24/25 Q1 RAG Status
Continued development of Digital Front door for patients	Extension of Waiting List Validation Implementation of Digital Letter Sending - Radiology Implementation of Digital Letter Sending - TrakCare	FIF-DIGI-12	9. Digital & Innovation	9.6	Mar-25	Green - On Track
Complete NHS Fife's Phase 2 M365 Programme	Secure tenancy and products Assessment of benefit from products Clarity on licence and capacity availability	FIF-DIGI-13	9. Digital & Innovation		Oct-24	Green - On Track
Enhanced data availability and sharing	Improved sharing and visibility of data between primary care and secondary care Demonstration of enhanced sharing controls in the systems Improve clinical decision making from the availability of data	FIF-DIGI-14	9. Digital & Innovation			Amber - At risk - requires action
Local - Records Management Plan Implementation	Compliance with legislations Reduction in data breaches Improved compliance with achieve and records deletion	FIF-DIGI-16	9. Digital & Innovation	9.2	Mar-26	Green - On Track
Digital Enablement Workplan for patients and staff ITIL 4 Improvement	Implementation of ITIL4 Process Move towards expression of Value not Service	FIF-DIGI-17	9. Digital & Innovation	9.4	Mar-25	Green - On Track
Delivery of ICO and NISD Audit Improvement Plans Architecture and Resilience Developments	Improved reliability and availability in key systems Improved response to incidents Improved compliance with standards Reduction in legacy technology	FIF-DIGI-18	9. Digital & Innovation	9.2	Mar-25	Green - On Track

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme Summary Update**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Tracy Crighton, Programme Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- NHS Board Strategic Priorities

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides Clinical Governance Committee with an update in relation to the delivery of Hospital Electronic Prescribing and Medicines Administration (HEPMA), including Pharmacy Stock Control (PSC) and Immediate Discharge Letter (IDL) and outlines progress to date and next steps for Fife. The report is provided for the Committee's **assurance**.

2.2 Background

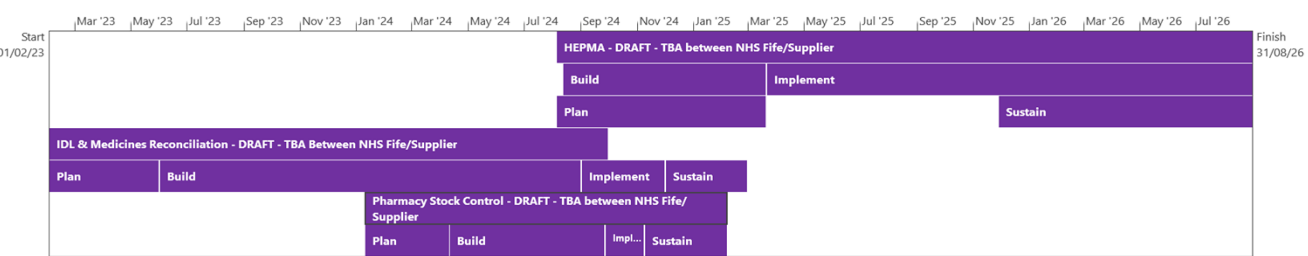
The revised HEPMA Business Case was submitted to the NHS Fife Board and approved in July 2022. Two components made up the contractual requirements; one for the Immediate Discharge Letter (IDL) solution supplied by Orion Health and the other for HEPMA supplied by System C managed through Change Control within an existing Patient Management Service (PMS) Contract which was awarded in December 2023.

As part of the contract award for HEPMA, System C agreed to include a new Pharmacy Stock Control system with no additional cost to NHS Fife. This will enable retiral of the existing stock control system which was end of life, and this solution was accepted by NHS Fife. This paper provides the Committee with an update on the status of all projects.

2.3 Assessment

NHS Fife have been working with the suppliers to validate timelines for HEPMA, Pharmacy Stock Control and IDL, Supplier proposed dates shown in diagram 1, to ensure compliance to contractual milestones and delivery dates were achieved as soon as possible.

Diagram 1 – Proposed programme timelines for HEPMA, Pharmacy Stock Control and IDL



IDL

The project underwent replanning as the product failed the 1st round of testing. The testing identified several key issues which would require further development by Orion (the supplier) to meet the needs of NHS Fife. NHS Fife have been working closely with the supplier to ensure a reliable, fit for purpose solution. A new implementation date of November 2024, however this was dependent on the supplier providing NHS Fife with the necessary changes. There have been subsequent challenges with supplier delivery of developments for testing, with escalation of non-delivery made, and testing incidents raised which require further changes by Orion to ensure the solution is fit for purpose. Negotiations with Orion senior leadership team have secured a reduction in capital costs in FY24/25 and ongoing revenue costs for NHSF, in response to the challenges faced to date to sufficiently develop the IDL solution to fit the requirements of NHSF. Digital remain in discussions with the supplier with an aim to achieve the November date.

HEPMA & Pharmacy Stock Control (PSC)

The planning stage continues, with the Project Team continuing to work with System C to undertake detailed project planning. Supplier proposed dates for rollout of Pharmacy Stock Control were September 2024 with the first implementations (supported by System C) of HEPMA by June 2025, which aligned to agreed contractual milestones. Subsequent updates from the Supplier have now confirmed an inability to deliver to the September go live date for PSC due to project plan omissions and reduced staff availability to deliver product training to NHSF project team. Escalations to System C senior leadership team have led to a collaborative approach to agree changes to dedicated Supplier resources and an updated detailed project plan. Challenges related to late delivery and missed contractual milestones are currently being assessed by NHSF and Supplier, with commitment to further

discussions in respect to System C failure to meet contractual terms and related financial implications to NHSF. The team are working to deliver a final signed off and agreed plan by September 24, with an agreement there will be no impact to the end date for HEPMA which is scheduled for August 26, however there may be an impact to scope.

Following completion of project planning, a revised Programme timeline, will be taken to HEPMA Programme Board for agreement and discussions with the supplier in relation to the contractual missed milestones will be undertaken. This will include the recovery of additional costs incurred by the Board for the extended use of the existing Stock Control system.

Scoping for IT equipment

Detailed scoping of ward IT kit requirements has concluded with key service stakeholders. As a result of this, additional mobile IT kit (computer on wheels) was identified as required, FCIG have considered a request for additional capital funding from FY25/26 budget, and a request to utilise the cost saving which was generated from the missed milestones by Orion. FCIG have agreed to the reallocation of Orion cost savings, noted above, to fund additional IT Kit and have also agreed to the progression of an IT Kit order to utilise this funding as well as the agreed funding within Business Case for FY 24/25.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

HEPMA will replace existing paper-based systems within prescribing and medicines administration, making processes more efficient, releasing time to care, significantly improving patient safety and quality of care. In addition, the new electronic systems will improve and bring consistency to the discharge process, medicines reconciliation and medicines management processes and enhance medicines optimisation. This will enable greater control over what is prescribed, how it is prescribed and how it is administered, addressing variation, minimising inefficiency, and improving quality.

2.3.2 Workforce

Circa 3,500 staff will be positively impacted by the implementation of HEPMA. Prescribers, including all medical staff, pharmacists and nurse/AHP Prescribers and Administrators.

Service engagement has begun to ensure cascade of information and commencement of preparatory work.

The agreed resource profile for NHS Fife has been implemented to ensure safe delivery of HEPMA within NHS Fife. This resource will also be utilised to take forward IDL and PSC.

2.3.3 Financial

HEPMA will support the Reform, Transform, Perform framework through alignment to the medicines optimisation workstream.

The funding for HEPMA delivery has been agreed by NHS Fife and Scottish Government. The budget has been discussed with finance colleagues and is within agreed tolerances except for the additional costs, as highlighted in this paper, for computers on wheels. Following discussions with Finance, agreement has been reached to move capital costs associated to missed Supplier contractual milestones from FY24/25 to FY25/26 and to also allow the cost saving negotiated with Orion Health, IDL & Medicines Reconciliation supplier, to be utilised to purchase additional IT Kit, so reducing the additional capital funding request from FY25/26. FCIG have recorded the HEPMA Programme request for additional £150K of capital funding from FY25/26, prioritised accordingly, and a decision is expected February 2025.

2.3.4 Risk Assessment / Management

Risks are managed in line with project governance and are reported to the HEPMA Programme Board. There are no red risks which require to be escalated.

The Supplier issues noted within this paper have resulted in increased pressure on the Programme to successfully complete implementation of all projects within the agreed Business Case timeline, end August 2026. The Organisation is also being asked to support an expedited implementation schedule whilst protecting operational delivery.

The delayed implementation of CMM Pharmacy Stock Control (PSC) results in an extended dependency on the current EMIS Pharmacy Stock Control system, increasing the Organisation risks given the current system is end of life, is unable to be upgraded and has a reliance on unsupported Windows 7 IT kit. Conversations will be required with EMIS to discuss the implications of NHSF reliance on current PSC beyond the contract end date, December 2024.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

An impact assessment has been approved and published for HEPMA as a concept on 01 October 2020 by NHS Fife Equality and Human Rights Officer.

2.3.6 Climate Emergency & Sustainability Impact

Reduction in the use of paper through implementation of electronic prescribing will contribute positively to the climate emergency and commitment to net zero.

2.3.7 Communication, involvement, engagement and consultation

- The HEPMA Programme Board have been kept up to date on delivery of contractual milestones and are involved in Programme re-planning activities.

2.3.8 Route to the Meeting

- The areas outlined within this paper have been discussed with Executive Directors Group and HEPMA Programme Board.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

- N/A

Report Contact
Tracy Crighton,
Programme Manager,
email Tracy.Crighton@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Information Governance and Security Steering Group Update**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy - SIRO**
Report Author:	**Alistair Graham – Director of Digital & Information**

1 Purpose

This is presented to for:
- Assurance

This report relates to a:
- Government policy/directive
- Legal requirement
- Local policy

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

2 Report summary

2.1 Situation

The Information Governance & Security (IG&S) Steering Group, through this report, provides oversight of its work and assurance for the key priorities for the 2024-25 period. The report is the first of two reports for the financial year 2024-25.

The Steering Group continue to support the tasks, activities and projects that are key to the continuous improvement, mitigation of risk and evidence of improved controls for the areas of IG&S.

Following a review of the Information Commissioners Office (ICO) Accountability Framework and the Scottish Public Sector Cyber Resilience Framework (SPSCRF), (which incorporates the Network Information Security Directive (NISD)), the IG&S Steering Group agreed to a revised Accountability and Assurance Framework, to provide a unified view of the current

controls, actions and activities undertaken across NHS Fife as we evidence our performance for compliance. The executive summary of the current IG&S Accountability and Assurance Framework (July 2024), that is presented to the Steering Group is provided in Appendix 1.

Reporting to the Steering Group covers the following areas: -

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individuals Rights
- Transparency
- Records of processing on a lawful basis
- Contracts and data sharing
- Risks and DPIA
- Records Management and Security
- Breach Response and monitoring

The prioritisation of activities is based on the outcome of the ICO external audit, completed in March 2023, the outcome of the Cyber Resilience Framework audit completed in September 2023, the current risk profile within IG&S, through direct instruction by competent or audit authority or via the guidance of the IG&S Steering Group.

The report is intended to provide **assurance** to the Committee.

2.2 Background

ICO Audit

The Information Commissioner is responsible for enforcing and promoting compliance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA18) and other data protection legislation. Section 146 of the DPA18 provides the Information Commissioner's Office (ICO) with the power to conduct compulsory audits through the issue of assessment notices. Section 129 of the DPA18 allows the ICO to carry out consensual audits.

NHS Fife (NHSF) was audited in March 2023, as part of a wider project looking at data protection compliance across the wider NHS in Scotland (NHSS), consisting of 22 audits of Territorial Health Boards and Special Boards in Scotland. The scope of the audits takes into account the Information Governance leads input regarding current data protection risks identified across NHSS as a whole as well as risks identified from ICO intelligence. A summary report for NHSS was published.

The purpose of the NHSF audit is to provide the Information Commissioner and NHSF with an independent assurance of the extent to which NHSF, within the scope of this agreed audit, is complying with data protection legislation.

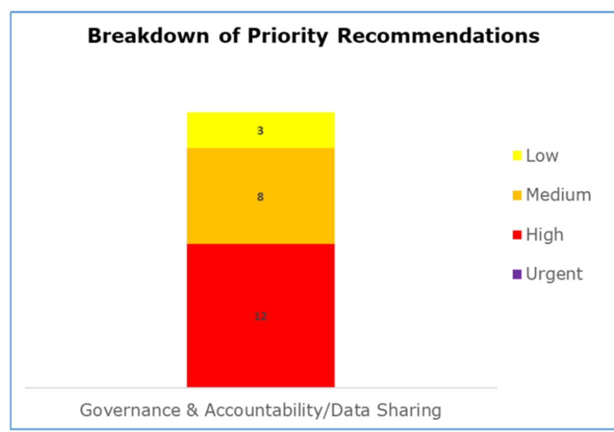
It was agreed that the audit would focus on the following area:

> The extent to which information governance accountability, policies and procedures, and information sharing agreements and logs which comply with the principles of all data protection legislation are in place and in operation throughout the organisation.

The ICO final report provided a rating indicator assessed against four levels of assurance - Very Limited, Limited, Reasonable and High. The summary rating from the ICO, following their audit, indicated a **reasonable assurance** rating for NHS Fife:-

Scope area	Assurance Rating	Overall Opinion
Governance & Accountability/Data Sharing	**Reasonable***	There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation.

The audit report went on to identify 23 action points based on a priority recommendation. The chart below shows a breakdown of the priorities assigned to the ICO priority recommendation: -



The recommendations have now been incorporated into the IG&S Accountability and Assurance Framework report and progress will be monitored by the IG&S Steering Group.

Risk Management

Through work guided by the IG&S Steering Group meetings in January 2023 and April 2023, it was agreed to the use the Board risk appetite description as part of its responsibilities for effective risk management. The steering group considered these descriptors and agreed the following levels of risk tolerance level for categories of risk:-

Risk Category	Tolerance Level
Data Breaches	LOW

Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

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

The summary risk position in July 2024 is: -

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	13	3	9	1
Infrastructure	Moderate	7	1	3	3
Access Controls	Moderate	3	0	2	1
Information Assets	Moderate	4	0	2	2
Supplier Management	Moderate	3	0	3	0
Threats and Vulnerabilities	Low	6	1	5	0
Operational Performance	Low	13	7	4	2
Total		**49**	**12**	**28**	**9**

Green risk items within tolerance.
30 risks out with tolerance.

Key Priorities
The IG&S Accountability and Assurance Framework details key areas of action for the year. These have been identified as:-

- Continued review of policy and procedures and alignment of the IG&S Accountability and Assurance Framework within policy content.
- Provision of role-based training for staff who have specific IG/Data Protection responsibilities.
- Implementation of Subject Access Requests improvements and single point of contact.
- Implementation of Records Management Plan.
- Delivery of the Action plan following the NISD audit.

2.3 Assessment

Updates to the key areas are included in this section.

Procedure and Policy review

A significant review of NHS Fife's Records Management Policy is currently being undertaken. This follows the publication of a revised Records Management Code of Practice for Health and Social care that was published in August 2024.

The Code of Practice does not constitute legal advice but seeks to supplement the existing associated legislation in this area.

This Code of Practice applies to data, information, and records, in any format, or stage of processing in the delivery of health care functions and associated supporting business services. This includes those handled by third parties on behalf of NHS Boards in connection with health care and associated administrative purposes. Formats include, but are not limited to:

- Paper
- Digital
- Email
- Scanned
- Audio/Video recordings
- Photographs/medical imaging
- Microform (microfiche/microfilm)
- Instant messaging/SMS
- Social media posts
- Website content (internet/intranet)

The Steering Group is also supporting the review of the policy associated with Non-NHS Equipment Policy.

Planned improvement to Information Asset Register and associated Service Catalogue

Work continues to catalogue the remaining information assets in use within NHS Fife, including those that have been mandated nationally.

A procedure has now been created and approved and its implementation will be support by the offer of training and continued discussion with service areas.

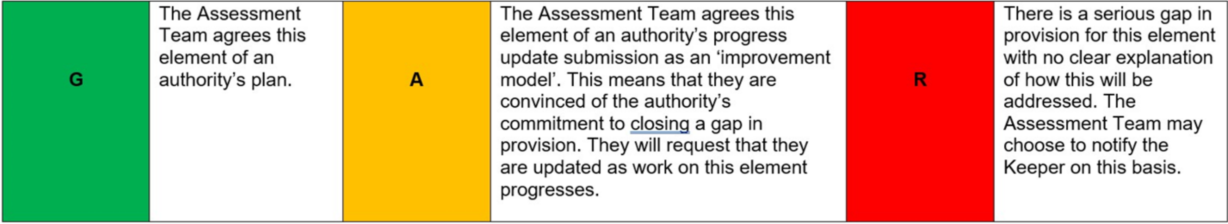
The establishment of the register will also allow cataloguing of existing contractual arrangements and associated supplier management expectations.

Implementation of Records Management Action Plan

While all 15 areas of the plan are being progressed, focus is being given to the two Amber areas of Business Classification and Audit trail, identified by The Keeper response to the NHS Fife Records Management Plan (January 2023).

A Progress Update Review (PUR) was provided to National Records Scotland in January 2024 and a response was provided in July 2024. The NRS assessment team use the following assessment criteria when considering a submission or update.

Key:



G	The Assessment Team agrees this element of an authority's plan.	A	The Assessment Team agrees this element of an authority's progress update submission as an 'improvement model'. This means that they are convinced of the authority's commitment to closing a gap in provision. They will request that they are updated as work on this element progresses.	R	There is a serious gap in provision for this element with no clear explanation of how this will be addressed. The Assessment Team may choose to notify the Keeper on this basis.

13 of the 15 areas remain in Green, with 2 areas marked as Amber. While focus is given to the amber areas, work continues across all 15 areas.

The report also notes:-

"The Assessment Team has reviewed NHS Fife's Progress Update submission and agrees that the proper record management arrangements outlined by the various elements in the authority's plan continue to be properly considered. The Assessment Team commends this authority's efforts to keep its Records Management Plan under review. NHS Fife continues to take its records management obligations seriously and is working to bring all elements into full compliance."

While every effort is made to continue progress with the implementation of the Records Management Plan, work associated with Re-form, Transform and Perform has had to take priority.

NISD Action Plan Implementation

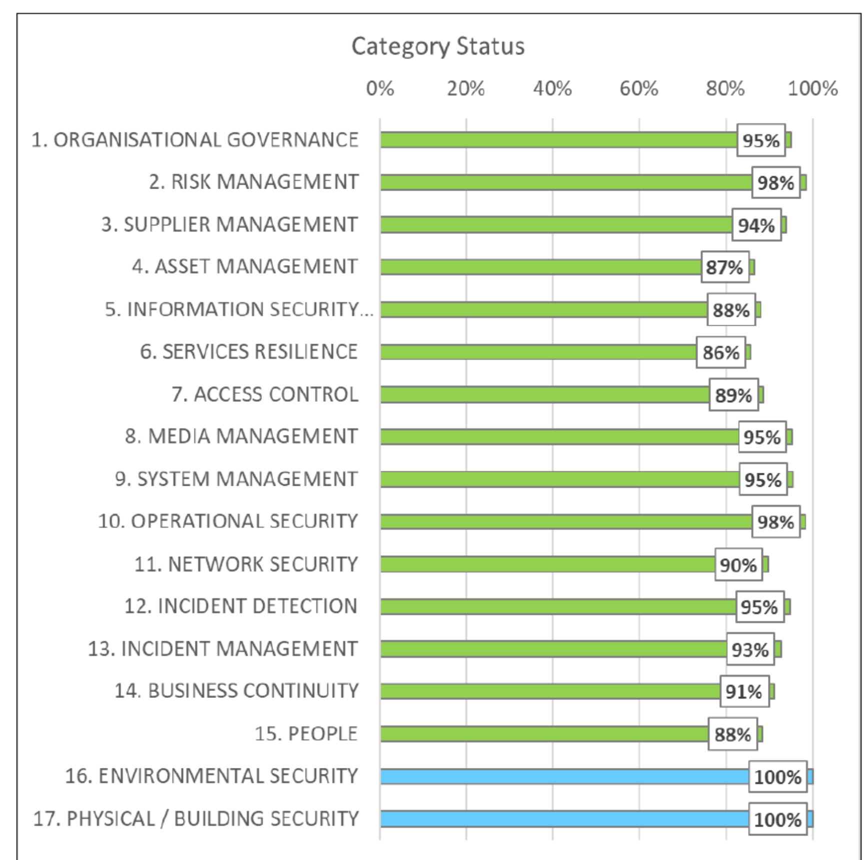
The NISD Audit work associated with the 2024 report has now been completed, with the final report provided in August 2024.

The prioritised action plan focussed on the following areas:-

- Supplier Management
- Asset Management (associated with Information Asset Recording)
- Privileged Access Controls and Network Segregation
- Resilience and Disaster Recovery Testing

The report outlines an overall compliance status of 93% and increase of 16% from the 2023 audit.

The 17 category status are shown below:-



All 17 categories and 59 of the 68 subcategories are rated at 80% compliance or above. Only 9 subcategories are less than 80%.

The report will be reviewed by the IG&S Steering Group and priorities being agreed for progress during the next audit cycle.

Incident Reporting

During the 12 month period July 2023 to June 2024, 14 incidents were reported to the ICO and/or NISD Competent Authority. During that period 3 incidents was not reported within the required 72-hour period.

One incident resulted in a reprimand from the ICO. The Information Governance and Security Steering Group consider this item at the July 2024, noting no further action was required by the ICO.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

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

Within the principals of the overarching privacy programme the rights of the individual (our patients) remain consistent with many of the principles of Realistic Medicine.

2.3.2 Workforce

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

The staffing levels within the Information Governance and Security team continue to be reviewed to ensure our compliance with legislation and to ensure the improvement programmes progress. There will continue to be a challenge in maintaining progress against the backdrop of the Re-form, Transform and Perform programmes.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

Many of the actions listed and prioritised have a direct bearing on Corporate Risk 17 – Cyber Resilience, that was presented to the Clinical Governance Committee in January 2024. This risk has a current rating of High.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

No other impact considered.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been previously considered by the following group as part of its development.

- The items contained are considered in detail by the Information Governance and Security Steering Group at their quarterly meeting.

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

The Committee is asked to **note** the progress being made across the IG&S domains and take **assurance** from the governance, controls and improvement plans in place.

3 List of appendices

- Appendix 1 – IG&S Accountability and Assurance Framework (Exec Summary) – June 2024

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

Information Governance and Security Accountability and Assurance Framework

Produced in July 2024

Introduction

The purpose of the ***Information Governance and Security (IG&S) Accountability and Assurance Framework*** is to provide a unified view of the current controls, actions and activities being undertaken across NHS Fife, as we evidence our responsibilities for compliance.

The ***IG&S Accountability and Assurance Framework (IGSAAF)*** is presented to the Information Governance and Security Steering Group on a quarterly basis and is available to all governance committees where appropriate.

The ***IGSAFF*** comprises of the following sections:

I. Executive Summary

a. Report sections and summary of frequency of updates
b. Performance Measures Summary
c. Risk Summary
d. Key Milestones and changes within reporting period

II. Performance Assessment Reports

a. Leadership and Oversight
b. Policies and Procedures
c. Training and Awareness
d. Individuals Rights
e. Transparency
f. Records of processing on a lawful basis
g. Contracts and data sharing
h. Risks and DPIA
i. Records Management and Security
j. Breach Response and monitoring

Section II provides further detail on performance measures relating to existing controls, actions and activities being undertaken for improvement, consideration of existing or emerging risk and a statement of assurance for the IG&S Steering Group to consider.

The prioritisation of activities places greater emphasis on feedback received from external and internal audit, guidance provided by external expert bodies e.g. Information Commissioners Office (ICO), National Cyber Security Centre (NCSC) and National Service Scotland's Cyber Centre of Excellence (CCoE), Internal Audit, internal risk assessment and internal event and breach response themes.

The ***IGSAAF*** has been developed following consultation and feedback from the IG&S Steering Group and following the consideration of a mapping exercise between the **ICO Accountability Framework** and the **Scottish Public Sector Cyber Resilience Framework** (***SPSCRF***) of which the **Network Information Security Directive** (**NISD**) is used as the current audit mechanism by Scottish Government's Competent Authority. The NISD audit only considers 80% of the controls within the ***SPSCRF.*** *

Following review of the mapping exercise it was decided that the core elements identified in the ICO Accountability Framework and Scottish Public Sector Cyber Resilience Framework

** Reference Cyber Resilience Framework V1.2 Section 1 Item 5*

provided key topics to support the continued development of an effective privacy management programme.

The ICO Accountability Framework assess organisations maturity against 10 categories. Each category has several expectations, 77 in total, with a total of 338 controls that organisations are assessed against.

For NISD the domain account is 4, with 17 categories with 101 expectations and 430 controls. New controls are being introduced in the 2023 audit.

The NSID Framework is a component of the overarching Scottish Public Sector Cyber Resilience Framework. Many frameworks exist within the cyber security sector including Cyber Essentials, Cyber Essential Plus and ISO27001, however the SPSCR incorporates best practice and controls from all.

I. Executive Summary

At each meeting, the Steering Group is asked to consider performance targets, controls and improvement actions identified across each of the 10 areas. This section of the report provides a summary of these indicators, where data is available, along with previous performance and where possible, benchmarking.

a. Report sections and summary of frequency of updates

Summary of the Framework Categories: -

Leadership and Oversight	Requirement for clear and documented governance structure in support of the assurance and management of IG&S activities and risks, across all responsible areas of NHS Fife. Key Leadership roles established including, but not limited to, SIRO, Caldicott Guardian, Data Protection Officer/s, Information Security and Cyber Security Manager. Evidence of reporting and assurance
Policies & Procedures	Through a range of policies and procedures, that are reviewed and updated on a regular basis, we can demonstrate visibility to staff and the public of the processes required for data protection, information governance and security. These policies and procedures seek to remonstrate data protection by design and default and ensure strong compliance with security controls in support of SPSCRF.
Training and Awareness	Evidence a considered approach to staff training and awareness programme that is linked to staff members employment lifecycle and role. This includes support for specialised roles, the ability to monitor impact of activities and support awareness raising where risks or incidents require corrective action.
Individual's rights	Consistently inform individuals (staff, patients and patient's representatives) of their rights to access information and have suitable processes and resources to handle just requests in a timely manner. This includes processes to rectify inaccurate or incomplete records and erase or restrict access or processing where individuals request. Individuals are also given access to recognise and respond to individual's complaints about data protection.
Transparency	Transparency helps individuals to exercise their rights and gives people greater control. This is particularly important if the processing is complex or if it relates to a child. Being transparent about what we do with personal data will support data sharing with third parties.
Records of processing and lawful basis	It's a legal requirement to document our processing activities. The main activities in support of this work include Information Asset Registers, associated Data Protection Impact Assessments (DPIAs) and consideration of consent models. The processing of data is easier and less risky when such documents exist and are maintained.
Contracts and data sharing	Through contractual mechanisms and DPIA the legitimacy and requirement to share data is a key consideration. Data sharing agreements are established and maintained and support the development of guidance or procedures. Contracts are required with all processors and a record is kept and maintained.
Risks and DPIAs	We have and maintain ways of identifying and managing risks associated with Privacy and Security. DPIAs are one way to identify risks and high risks, relating to privacy, require reported to the ICO.
Records Management and Security	The implementation of NHS Fife's Records Management Plan is key in supporting the accountability principles and maintain the security of data we create, retain and destroy. How and who access this data is key to maintaining security and this is supported by Business Continuity and disaster recovery plans.
Breach Response and monitoring	The requirement to detect, investigate and record any breaches is fundamental to this category. Personal data breaches can have a range of adverse effects on individuals and to NHS Fife. The requirement to notify the ICO of personal data breaches is 72 hours and is a key measurement in this area.

The reporting frequency for each section and the current availability of measures is noted below: -

Table 1 - Category Relevance, Update Frequency and Measures

Category	Relevant to ICO Accountability Framework	Relevant to NISD/Cyber Resilience Framework	Frequency of Update	Measures Established
Leadership and Oversight	Relevant	Relevant	Annually	Yes
Policies & Procedures	Relevant	Relevant	Quarterly	Yes
Training and Awareness	Relevant	Relevant	Quarterly	Yes
Individual's rights	Relevant	Not Relevant	Monthly	Yes
Transparency	Relevant	Not Relevant	Quarterly	None
Records of processing and lawful basis	Relevant	Not Relevant	Quarterly	Yes
Contracts and data sharing	Relevant	Some Relevance	Monthly	None
Risks and DPIAs	Relevant	Relevant	Quarterly	Yes
Records Management and Security	Relevant	Relevant	Monthly	None
Breach Response and monitoring	Relevant	Relevant	Monthly	Yes

We have completed the 2023/24 NISD/Cyber Resilience Framework Audit cycle. Findings and the review of the report, associated are included in the Accountability and Assurance Framework.

b. Performance Measures Summary

Table 2 - Summary Performance Measures

Operational Performance

Information Governance & Security Performance Summary	Target	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Cyber Security - Exposure Score*	< 25	25	63	32	45	33	33	29	31	32	34	45	65	62
FOI's - Responses within target	85%	88.0%	84.9%	78.0%	86.50%	89%	97.1%	84.4%	91.6%	85.0%	77.9%	83.3%	85.9%	84.8%
Number of SARs Received					204	218	226	146	228	247	221	241	243	204
SARs Received (% responded to timeously)	100%	95.0%	?	?	100%	95.1%	97.3%	87.6%	94.5%	92.7%	92.7%	89.9%	94%	94.2%
Information Governance Incidents	Avg 109	117	113	120	109	89	96	82	105	135	89	106	114	90
Incidents Reported to ICO or CA		0	2	4	2	0	1	0	0	0	2	1	0	2
Incidents Reported within 72 Hours		0	2	3	2	0	1	0	0	0	2	0		1
Follow up required by ICO		0	0	4	2	0	1	0	0	0	1	0		1
Mandatory Training Renewal **	80%			54%	54%		59%			61%			62%	
Annual Measures		2020	2021	2022	2023	2024								
NISD Compliance Status		53%	69%	76%	87%									
NISD Risk Exposure		13%	8%	3%										
NISD Controls Completed		53%	58%	64%										
Public Sector Cyber Resileince Compliance					77%									

Technical Incidents

	NIS / GDPR Reportable	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
1. Negligible Incidents	N	3753	2934	3865	3622	3919	3865	2633	3476	3364	3199	3429	3215	
2. Minor Incidents	N	2		3			2	3	5	3	3	3		
3. Moderate Incidents	Y			1				1			2			
4. Major Incidents	Y													
5. Extreme Incidents	Y													

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

** - Only partial information available from SAR teams

*** - Source EDG Training Compliance Report

c. Risk Summary – July 2024

The IG&S Steering Group has agreed to the use of the Board risk appetite description as part of its responsibilities for effective risk management. The following definitions are:-

a) **Low** - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities. (This would be demonstrated by a risk rating less than or equal to 6)

b) **Moderate** - Prepared to accept only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation. (This would be demonstrated by a risk rating that is more than 6 but less than 12)

c) **High** - Willing to consider and / or seek all delivery options (original / ambitious / innovative) and accept those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk. (This would be demonstrated by a risk rating that is more than 12 but less than 20. A risk rating of 20 or 25 being unacceptable for all risks)

D&I will aim to apply the overarching definitions to the risks concerned with its operational responsibilities including IT/Cyber infrastructure.

The IG&S Steering Group has agreed to the following risk tolerance levels for the following categories of risk:-

Table 3 - Risk Category and Tolerance Levels

Risk Category	Tolerance Level
Data Breaches	LOW
Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

The full detail and definitions can be found in the Digital and Information Risk Management Statement.

Summary Risk Position on 22nd January 2024

Table 4 - Summary Risk Position – IG&S Only

Risk Level	Initial Risk Level	Current Risk Level	Previous Period Risk Level (April 2024)
High Risk	19	**9**	**9**
Moderate Risk	11	**16**	**16**
Low/Very Low Risk	0	**5**	**5**
Total	30	**30**	**30**

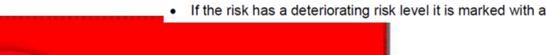
Three new risks have been identified in the period.

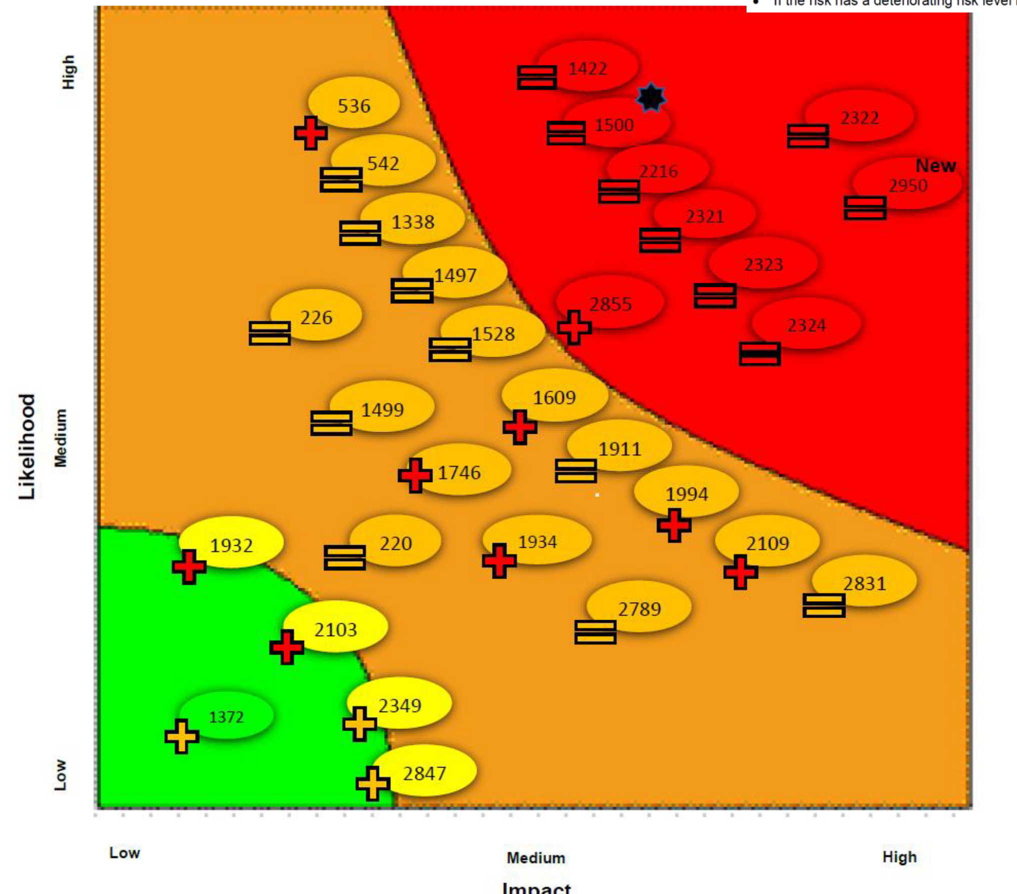
Table 5 - Risk Summary by Category all D&I Risks

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	13	3	9	1
Infrastructure	Moderate	7	1	3	3
Access Controls	Moderate	3	0	2	1
Information Assets	Moderate	4	0	2	2
Supplier Management	Moderate	3	0	3	0
Threats and Vulnerabilities	Low	6	1	5	0
Operational Performance	Low	13	7	4	2
Total		**49**	**12**	**28**	**9**

Green risk items within tolerance
30 risks out with tolerance – 61%.

Figure 1 - Risk Visualisation by Risk Rating





d. Key Milestones and changes within the reporting period

Progress in period April 2024 to July 2024.

The assurance framework has been updated to include key priorities from the Cyber Assurance Framework Annual Audit and where linked high-level risks are now detailed within each category.

a) Leadership and Oversight

This section shows the completion of the previous financial year activities associated with the Steering Groups review of Terms of Reference and Annual Workplan. Assurance updates will be provided to Clinical Governance Committee in September 2024 and March 2025.

b) Policies and Procedures

No Policies were presented to EDG in the period.

With Policy Group:-
GP/I3 – Internet Policy
GP/S8 – D&I Incident Management Policy
GP/D3 – A9 – Information Asset Register Procedure

Been Reviewed and Available for Consultation: -
GP/M5 – Mobile Device Management Policy
GP/E7 – Non NHS Equipment Policy – supporting risk assessment being established

c) Training and Awareness

Mandatory training compliance for IG&S modules has increased to 62% by May 2024.

d) Individual Rights

FOI performance was within target for 1 of the last 3 months.

SAR performance is challenging against the 100% target. In the last 3 months there has been a monthly average of 229 requests.

e) Records of processing and lawful basis

The requirements of Article 30 are partially in existence and require further work to improve. This work is captured within the ICO Audit Action Plan also.

The project to establish an information asset register baseline is now complete. While returns have not been received from all areas, further remedial work will commence.

f) Contract and data sharing

Work has concluded with NSS in support of providing additional evidence under the Cyber Assurance Audit. This evidence has been submitted to the auditor and the action is marked as complete.

g) Risks and DPIAs

DPIA procedure is out for consultation with stakeholders.

h) Records Management and Security

Work ongoing. SBAR update is included in the Steering Group's agenda.

Assurance Summary

The details of the report, KPIs, progress with the workplans and alignment to external and internal audit allows the following level of assurance to be provided:-

Level of Assurance:			
Substantial Assurance	**Reasonable Assurance**	**Limited Assurance**	**No Assurance**
	Current Level A reasonable level of assurance is provided to the Steering Group.		

NHS Fife

Meeting: **Clinical Governance Committee**

Meeting date: **6 September 2024**

Title: **ICO Reprimand - St Andrews Community Hospital**

Responsible Executive: **Margo McGurk, Director of Finance and Strategy – SIRO**

Report Author: **Alistair Graham, Director of Digital & Information**

Executive Summary:

- Report provides a moderate level of assurance for the committee.
- Report outlines the direct act, by a member of the public to present to St Andrews Community hospital as a bank worker.
- Report outlines the detail of the incident.
- Report outlines the actions taken to provide a response to the Information Commissioners Office.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Legal requirement
- Local Policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to update the Committee on the status, circumstances and learning associated with a data breach relating to St Andrews Community Hospital. This follows the reporting of the incident to the Information Commissioner's Office (ICO) and the receipt of a reprimand from the ICO.

The report is provided for assurance.

2.2 Background

In February 2023, an individual arrived at Ward 2 at St Andrews Community Hospital claiming to be a bank nurse for the late shift and was dressed in an NHS Scotland nursing uniform. The Lead Nurse could not find the individual's name on bank staff system and emailed the bank staff office who replied that the person was not known to them.

The Lead Nurse challenged person requesting to see some identification. The individual claimed they did not have any identification on their person or in their bag, so stated they would go to their car to collect some identification from their purse. The individual then left the staff room to go to car, leaving their bag in room. When the Lead Nurse checked approximately 5-10 minutes later as the individual hadn't returned, it was noted the bag had gone from staff room and there was no sign of the person.

During the period of the individual arriving and the time to verify their identification the individual was provided, by a staff member going off duty, with a paper copy of Handover SBAR containing some patient details. The SBAR contained: NAME, CHI, AGE, GP, DATE ADMITTED TO WARD, RESUS STATUS, REASON FOR HOSPITALISATION, PAST MEDICAL HISTORY AND ASSESSMENTS/TREATMENTS ONGOING, for 14 patients within the ward. There was no unsupervised access to other patient data and all records were confirmed to be intact. No report of missing / stolen personal items from patient(s), however person did assist another Healthcare worker with patient personal care.

Following the incident and an initial review the ICO was notified about the incident as required. Following a period of information sharing and meeting with the ICO, the ICO notified NHS Fife on 8 August 2023, of the intention to issue a reprimand to the Board.

On 28 November 2023, the ICO concluded their investigation into the matter and published NHS Fife with a reprimand.

2.3 Assessment

The ICO invited NHS Fife to provide a progress update to the ICO by the 6th of June 2024, on the following points:

- NHS Fife should consider improving their overall training rate, in line with current legislation. In the course of the investigation, it was noted that refresher training is taken three-yearly. NHS Fife should consider giving refresher data protection training to all staff more frequently. This should be underpinned by written guidance for employees to follow and NHS Fife should satisfy itself that security is discussed within the training and guidance.
- At the time of the breach, it was noted that NHS Fife did not have any written guidance or policies in relation to ID verification. NHS Fife should consider developing the guidance or a policy in relation to bank staff attending the hospitals.

- NHS Fife should review all policies available from their intranet. If archived versions are needed on the system these should be clearly marked as a previous version.
- In order to ensure compliance with Article 33 (1), NHS Fife should revisit their data breach reporting process and ensure relevant personal data breaches are reported within 72 hours. UK GDPR data breach reporting (DPA 2018) | ICO

The Head Information Governance and Security sent a letter to the ICO on 5th June 2024 advising of the progress made to the above points, and the response is attached as Appendix 1.

The ICO acknowledged receipt of the response.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Not applicable.

2.3.2 Workforce

Information Governance and Security (IG&S) training within NHS Fife is mandatory, IG&S offer a Professional Development Programme for employees to further their data protection knowledge. Compliance figures have increased.

2.3.3 Financial

ICO can fine NHS Fife for data breaches. Fines come in two tier levels:

Lower tier – 2% or £8.7 million of available funding, whatever is higher.

Higher tier – 4% or £17.5 million of available funding, whatever is higher.

2.3.4 Risk Assessment / Management

There are no active risks on the register relating to this data breach or the ongoing training compliance rates.

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

The SIRO, Caldicott Guardian and IG&S Steering Group have been kept up to date throughout this breach.

2.3.8 Route to the Meeting

The monitoring and consideration of this item has been conducted via:-

- Incident Review Group
- Information Governance and Steering Group – January 2024 and June 2024 meetings

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

- Appendix 1 - NHS Fife Letter to ICO – June 2024

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

Appendix 1

NHS Fife, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU
01592 643355 | www.nhsfife.org

NHS Fife

Date: 05 June 2024
Your ref: INV/0027/2023
Enquiries to: Margaret Guthrie
Direct line: 01383 565194 | Extension: 35194 | Email: fife.dataprotection@nhs.scot

Dear Lois

NHS Fife Reprimand

I refer to your reprimand, issued 28th November 2023, whereby you invited NHS Fife to provide an update by 6th June 2024 on the following points:

1. **The effectiveness of the standard operating procedure in relation to bank staff attending the hospitals.**

   - Staff Bank Operational Guidelines amended to reflect changes communicated by email - 15.5.24.
   - Staff Bank Admin Team will only use these guidelines in future.
   - Staff Bank amended Operational Guidelines have been sent out to all staff holding a Bank contract today. The email also provides the information below (Q2) communicated by email 16.5.24
   - The Clinical Services have been advised of the information below from both Associate Director of Nursing (ADoN's) 16.5.24.
   - The agencies have been reminded of their contractual obligations in reference to Worker ID and evidence to be supplied to clinical areas communicated 16.5.24.
   - A request has been made to NHS Fife Communications Team to be communicate to the organisation on StaffLink on 16.5.24.

2. **The implementation and effectiveness of the ID Process for new staff and bank agency staff.**

   - All supplementary staff working within NHS Fife (Bank / Agency) must wear their Photo ID Badge whilst working on NHS Fife Premises or carrying out duties for NHS Fife.
   - All supplementary staff must report to the person in charge of the ward or department on arrival, displaying their Photo ID Badge
   - NHS Fife Bank staff must have an ID Badge provided by the NHS Fife security team.
   - Agency staff should be able to provide clear identification which matches their Photo ID Badge on request by person in charge of the ward or department (Passport or UK photo driving licence)
   - Any supplementary staffing who attends NHS Fife premises without appropriate Identification may not be permitted access to carry out the shift unless identity can be verified.

3. The data protection training rates and the steps taken to improve this.

The Executive Director Group (EDG) in NHS Fife have recently confirmed the organisation's commitment to improving all core/statutory training compliance rates **to 80% by 31.5.25** as seen in the confirmed corporate objectives for 2024/25.

NHS Fife are reviewing all core / mandatory training syllabuses and re-fresher timescales in accordance with the Once for Scotland agenda. This review will include taking account of the non-pay elements of the 2023 pay award on the provision of services, specifically the introduction of the reduced working week and dedicated learning time, to achieve the appropriate balance of planned work activities whilst maintain safe and appropriate levels of care to the population of Fife. Following this review, and working with subject matter experts, we aim to introduce a revised core / mandatory training programme from April 2025.

Current Information Governance core skills/mandatory training provisions:

Learning Course	Refresh Period	Target staff group	Completion time
NHS Fife: Information Governance eLearning **OR** Information governance: safe information handling eLearning	3 Years	ALL employees	1 hour per employee (every 3 years).
NHS Fife Corporate Induction Support Services Induction	One-time completion	All new employees, on commencement of role	1 day (full Induction learning) – one off.

Current NHS Fife Compliance rates:

- IG Compliance rate (as of January 2024) = 61%
- Current IG compliance rate (as of April 2024) = 64%

Some considerations in adopting IG training as seen in the ICO recommendation:

- Reducing refresh for IG from 3-yearly to annual will initially result in an increased demand in time provision of circa 6,600 hours to ensure all employees complete IG training in the new refresh period.
- Maintaining annual refresh will then require circa 10,000 hours (1 hour per employee)
- Awareness raising via alternative channels may have more impact than reducing the refresh period (eg Targeted communications associated to wearing badges/challenges non-badge wearers)
- Awareness campaigns to spotlight all employee responsibilities regarding safety and security may be beneficial.
- The subject matter expert (eg Info Governance) is best placed to offer this perspective on how current our provisions are in line with legislation.
- Any underpinning written guidance on data protection/information governance that must be shared with all employees is best sourced from subject matter experts.
- Relevant Subject matter experts are best placed to advise NHS Fife on the adequacy of

security within the training and guidance issued to employees.

What the learning and development team can do if NHS Fife approve is:

A. Update TURAS LEARN to reduce the refresh of 3 yearly to annually for the NHS Fife Information Governance eLearning module.
B. Verify with NES if NHS Fife can reduce the refresh of 3 yearly to annually for the NHS Scotland information governance – safe information handling eLearning module.
C. Refresh the Core Skills Guidance Document available to all employees in Fife, to illustrate the annual requirements of Information Governance.
D. Work with the Digital and Information Department to raise awareness of the refreshed / new requirements associated with Information Governance eLearning.
E. Promote alongside the suite of all core skills training needs as per BAU for the learning and development team.

4. The steps taken to update the relevant policies in line with the UK GDPR.

As per NHS Fife's answer to question 21b posed by ICO on 21st March 2023, the document provided was the result of a search on StaffLink and had been superseded twice. It would appear that an old version annexe had remained on BLINK and hence was provided in error by the Service area and missed by the Data Protection Office when returning the response to the ICO. The NHS Fife Information Governance and Data Protection Policy was up to date at the time of the incident and remains so today: https://www.nhsfife.org/about-us/policies-and-procedures/general-policies/information-governance-data-protection-policy/

All previous versions and annexes are no longer available on StaffLink.

I hope that this information is of some assurance to the Commissioner in NHS Fife's commitment to learn from this unfortunate incident.

Yours sincerely,

M Guthrie

MARGARET GUTHRIE
Head of Information Governance and Security
NHS Fife Data Protection Officer

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

Executive Summary:

- Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR).
- A new single point of contact (SPOC) has been assigned for each Directorate.
- A new “investigation template” has been created to replace the “statement memo”.
- Stage 2 complaints: there is now a level of detail that clarifies where each complaint is in the process. Data taken from the first week in August 2024 shows there are 59 stage 2 complaints.
- Clinical pressures and absences within Services continue to impact performance, particularly with obtaining statements, final response approval, and the processing of complaints.
- All Services are being reminded of the importance of local resolution with a direct dialogue between the Services and the Complainant.
- The promotion of Care Opinion within the Organisation continues.

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Government policy / directive
- Local policy
- NHS Board Strategic Priority/ies – To Improve Quality of Health & Care Services

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 33% by 31st March 2024)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national timeframe standards.

2.2 Background

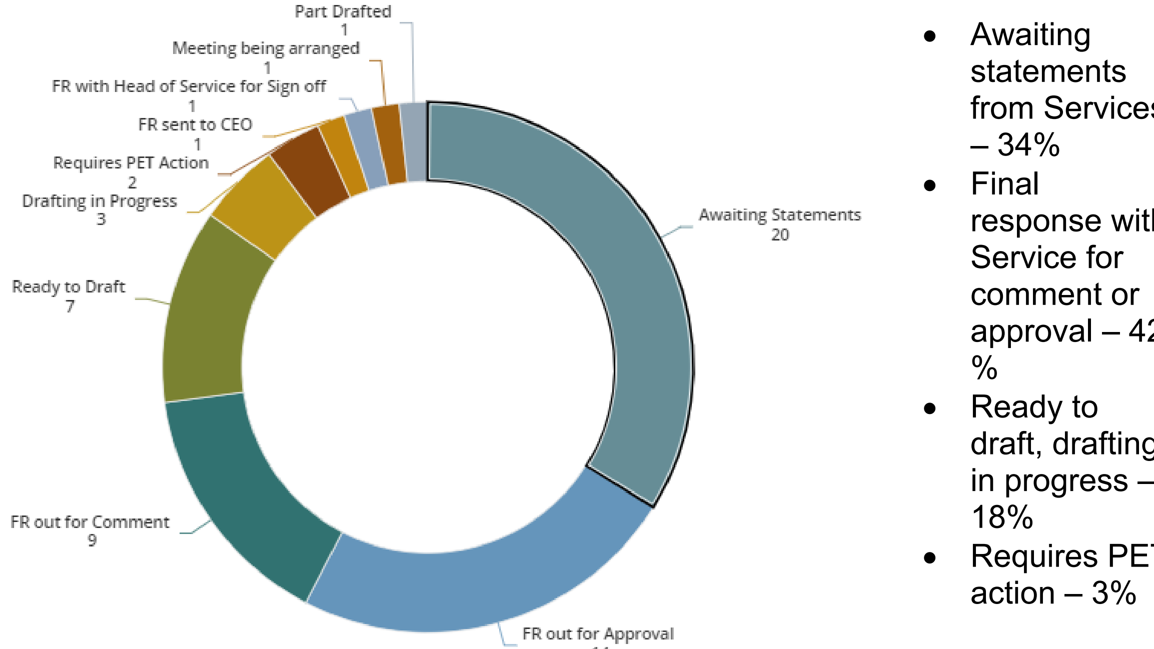
Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

2.3 Assessment

To improve efficiency within the Patient Experience Team, a new single point of contact (SPOC) has been assigned for each Directorate. The SPOC ensures that all new complaints, concerns, and enquiries are directed to it for prompt distribution, minimising delays previously experienced when using separate distribution lists for each Directorate or Service. All major or extreme complaints are still appropriately escalated within the organisation to relevant individuals and sent to the SPOC as new complaints.

With stage 2 complaints, there is now a level of detail that clarifies where each complaint is in the process. Data taken from the first week in August 2024 shows there are 59 stage 2 complaints with the following delays in the process:



- Awaiting statements from Services – 34%
- Final response with Service for comment or approval – 42 %
- Ready to draft, drafting in progress – 18%
- Requires PET action – 3%

In the last week of March 2024 (Q4), there were 60 stage 2 complaints. This increased to 76 in May 2024, reducing again to 60 stage 2 complaints at the end of July 2024. At the end of June 2023 (Q1), there were 152 stage 2 complaints and 75 stage 2 complaints at the end of June 2024, a reduction of 46% over the last year.

Clinical pressures and absences within Services continue to impact performance, particularly with obtaining statements, final response approval, and the processing of complaints. The Patient Experience Team continue to face absences due to short term and long-term sickness which contributed to a rise in Q1 with complaints awaiting PET action or drafting. It has also impacted on the Patient Experience Teams ability to progress Stage 1, concerns, and enquires. To address these issues, all Services are being reminded of the importance of local resolution with a direct dialogue between the Services and the Complainant. This proactive approach to complaint resolution is crucial in maintaining a high level of patient experience.

All Services have been reminded of the significant benefits this approach brings to patients, staff, and the Organisation, improving patient satisfaction and Experience, providing emotional relief for patients, contributing to their overall well-being, enhancing the quality of care, reducing workload, professional growth, significant stress reduction, cost savings, reputational management, and compliance with regulatory standards and

timeframes. Local resolution will also prevent delays as a written response will not be required, thus speeding up the process of providing a response and improving compliance targets.

The promotion of Care Opinion within the Organisation continues with the Patient Experience Team regularly visiting clinical areas to offer support, training, and guidance, along with sharing good practices from other regions. Responders are encouraged to add the photograph to their profile page to help those telling their story on Care Opinion feel like they are conversing with a real person and that staff are reaching out to them from one human being to another. A profile picture makes staff more visible and more human, bringing comfort and ease to the person reading it and removing any confusion about who is responding.

A new “investigation template” has been created to replace the “statement memo”. It is easier to complete, less repetitive and focuses mainly on the quality of the response and identifying any learning. A quality assurance check has been added so the person completing the investigation template knows how it should be completed. The Service can ensure the response fully covers the complaint points and is written well. The Patient Experience Team can complete the quality check and provide feedback to the Service or the staff member if required. This new template was initially tested within the Medical Directorate, where it received positive feedback, and now has been rolled out to all other Directorates. The new investigation template aims to improve the quality of the complaint response and support the completion more promptly.

This report provides the following Level of Assurance: (add an ‘x’ to the appropriate box)

	Significant	Moderate	Limited	None
Level			x	
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from complaints and adverse events, which can be triangulated with activity and staffing resources.

By analysing data from patient experience feedback offers significant insights into improving the quality of care and services. This process, when combined with regularly reviewing themes, trends, and lessons learned, can identify critical areas for improvement and help develop strategies to enhance patient experience, safety, and outcomes.

Integrating the principles of realistic medicine, such as shared decision-making, encourages collaboration between patients and healthcare providers to make informed choices based on patient preferences and values. By tailoring healthcare services to individual needs, can help avoid unnecessary treatments, focusing on what matters to the patient. Encouraging

collaboration between patients and healthcare providers to make informed choices based on patient preferences and values.

Ensuring healthcare delivery is aligned with patient needs and values, achieving the best possible health outcomes that matter to patients rather than merely providing services, ultimately leads to better health outcomes and value-based care. Measuring success based on patient satisfaction and experience can ensure that the care provided aligns with patient expectations and improves their quality of life.

Reducing harm and waste by minimising interventions that do not provide significant benefits, ensuring resources are used efficiently to provide high-quality care, and avoiding unnecessary expenses. By triangulating complaints with activity and staffing resources, the organisation can optimise resource allocation to areas most in need, ensuring better service delivery. Lessons learned can drive the development of more personalised care, improving patient satisfaction and outcomes. Patient engagement and trust in the healthcare system can improve with enhanced communication strategies based on feedback.

This approach improves patient satisfaction and supports the proactive promotion of wellbeing and public health campaigns, ensuring they address community-specific concerns and needs. Analysis of complaints may highlight disparities in care, prompting targeted interventions to ensure equitable health services for all populations. Feedback can uncover barriers to accessing care, leading to initiatives that improve accessibility, for example, the employment of a BSL Interpreter to support our deaf community.

However, it is important to recognise that high volumes of complaints and adverse event reports can overwhelm the system, leading to delays in addressing issues. This can negatively impact the quality of care and service resources. Continuous focus on negative feedback without adequate support can contribute to staff burnout and turnover, adversely affecting service quality. Care Opinion, which provides a significant amount of positive feedback, provides a ‘counter balance’ to negative feedback received.

By analysing data from patient experience feedback, NHS Fife can make informed decisions to enhance the quality of care and services. Integrating the principles of realistic medicine, such as shared decision-making and personalised care, ensures that healthcare delivery is aligned with patient needs and values, ultimately leading to better health outcomes and value-based care.

2.3.2 Workforce

Workforce planning

The Patient Experience Team completed a professional judgment tool for staffing, and this data is currently being reviewed. Currently, the team establishment consists of a 1.0 WTE Band 7 team leader, 3.6 WTE Band 6 Patient Experience Officers, 1.8 WTE Band 4 Patient Experience Support Officers, 2.07 WTE Band 3 Patient Experience Administrators, and 1 Band 4 Senior Patient Experience Administrator. A Band 6 Bank (retired) Patient Experience Officer (0.27 WTE) continues to support drafting complaint responses.

Discussions have taken place with the Volunteering Lead, to recruit Volunteers to support in gathering patient feedback in the form of Care Opinion and Lived Experiences. There are two candidates interested who are going through the recruitment process with a further two candidates who have shown an interest in supporting.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk as it enables the organisation to address issues proactively, improve services, communicate transparently, build trust, comply with regulations, and foster a culture of continuous improvement. Actively contributing to a positive reputation and a stronger more resilient organisation.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

EDG 15 August 2024

2.4 Recommendation

This paper is provided to members for a **"limited"** level of assurance.

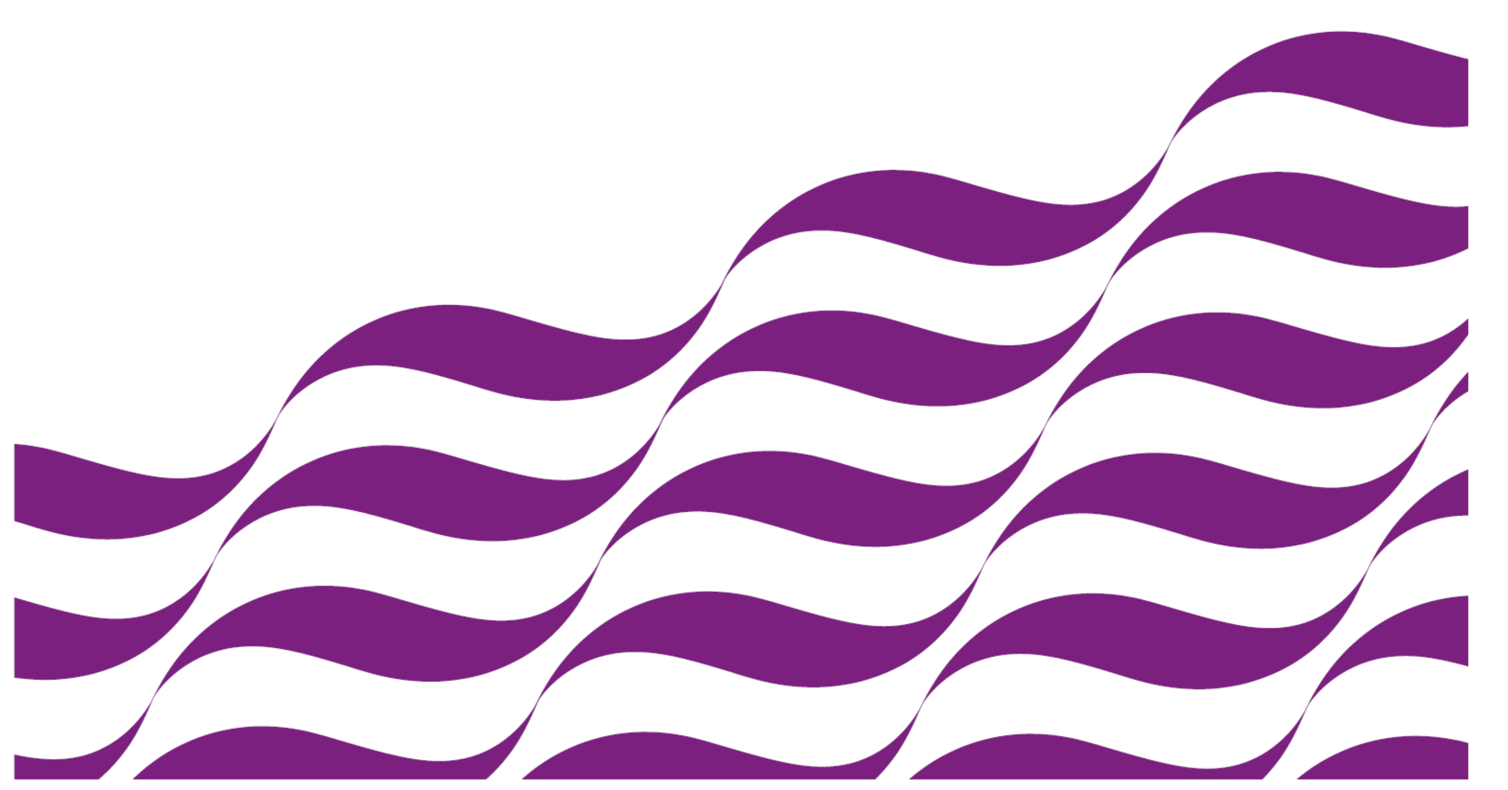
3 List of appendices

- Appendix 1 - Patient Experience & Feedback Annual Report 2023-24

Report Contact:
Siobhan McIlroy, Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

Patient Experience and Feedback

Annual Report 2023 - 2024



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Published Month Year
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www.nhsfife.org

CONTENTS

Introduction 2

Measuring the Experience 3

Improving the Experience 9

Scottish Public Services Ombudsman 10

Model Complaints Handling Procedure 11

Introduction

Person-centred Care

Person-centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- Respect for patients' values, expressed needs and preferences
- Coordination and integration of care
- Communication, information, education,
- Physical comfort
- Emotional support
- Involvement of family and friends

How Do We Know We Are Getting It Right?

Defining the patient experience

Patient experience is based partly on the patients' and families' *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system. We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment.

Measuring the experience

'Patient experience and feedback' is captured by a number of different methods, including:

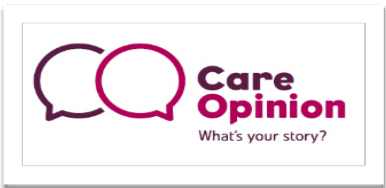
- Care Opinion
- Compliments and comments
- Complaints
- Care Assurance processes, for example: Shadowing / observation; Walkarounds.
- Surveys (2023/24)
- Post discharge phone calls (2023/24)
- Social Media
- Advice & Advocacy Services

Improving the experience

It is important to analyse the data, identifying themes and any particular issues:

- Develop and share goals and targets based on data
- Lessons learned, improvement actions developed, successes celebrated
- Create an enabling infrastructure: Framework; Leadership; Education and training
- Engage staff, patients, families and carers in improvement work
- *'Warm welcome / fond farewell' (2023/24)*
- 'You said… We did'
- Focus groups (2023/24)
- Initiatives, such as the Care Experience Improvement Model

Measuring the Experience

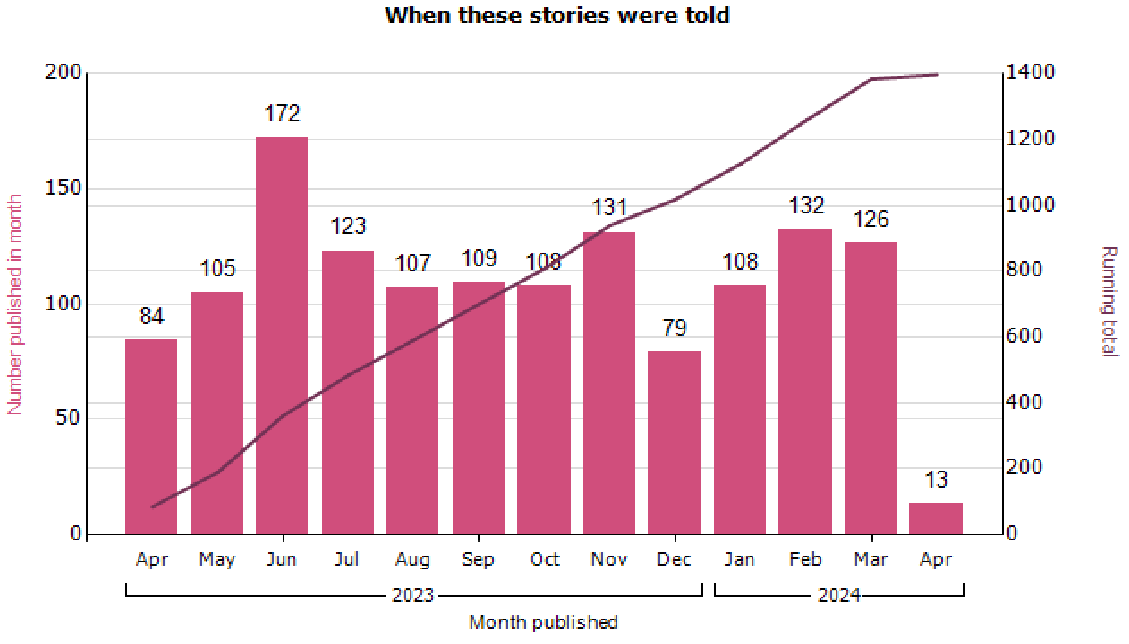


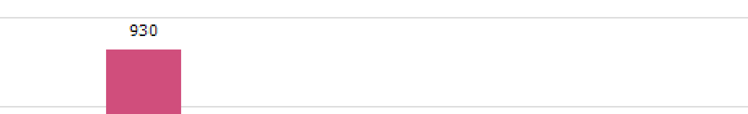
Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning and making changes. NHS Fife is one of the top performing NHS Scotland Boards.

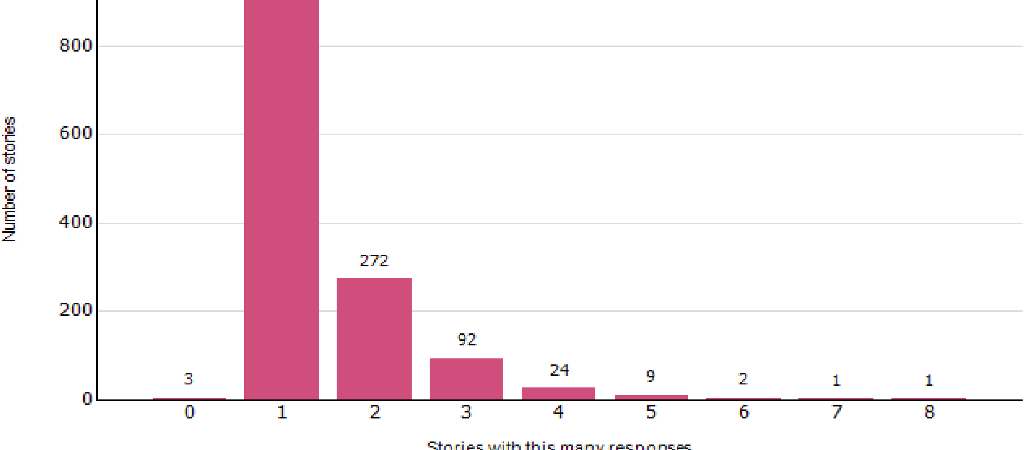
NHS Fife's **Care Opinion** highlights for 2023 - 2024:

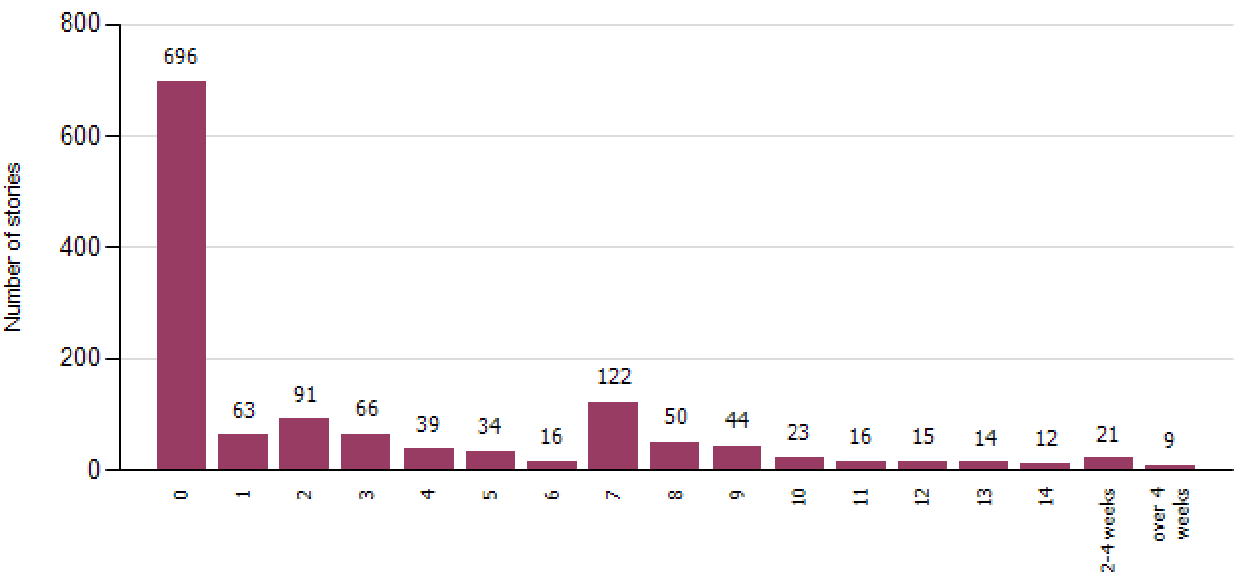
- **1,397** stories, viewed **154,324** times in all
- **365** responders

The graph below shows the distribution of stories received between April 2023 and March 2024.









In 2023/24 Care Opinion moderators rated the stories as:

- Not critical 83% (1160)
- Minimally critical 4% (53)
- Mildly Critical 9% (120)
- Moderately critical 4% (58)
- Strongly critical 0% (6)

Most common tags added by authors to these stories

What's good?	
staff	430
friendly	262
professional	236
nurses	204
communication	171
helpful	162
level of care	160
caring	156
Care	144
nurse	120
reassuring	120

What could be improved?	
communication	65
staff attitude	25
waiting time	25
information	16
appointments	15
food	13
waiting times	11
medication	10
not being listened to	10
pain relief	9

Feelings	
Thankful	202
grateful	196
supported	170
reassured	162
cared for	160
put at ease	145
well looked after	119
relaxed	116
informed	101
comfortable	94

These are the two most popular stories, out of all the stories included in this report

Dads stay Ward 2 Glenrothes Hospital – 633 views

Posted by squeezy1 as a relative

My dad was admitted into ward 2 Glenrothes Hospital in January this year having spent the previous 5 months in Victoria Hospital. My dad has several co-morbidities on top of this was diagnosed with hypo delirium and was recovering from a hip fracture he was refusing to eat and take his meds.

The difference in my dad since moving to ward 2 at Glenrothes has been incredible. He no longer displays symptoms of delirium, he is able to walk with a zimmer frame, he is eating well, put weight back on and taking his meds.

I cannot thank the staff enough for the care they have gave my dad. The staff are always friendly, easy to approach and kept me updated with my dad's care.

My dad was in tears when he left the hospital as he said ' I will miss the staff'.

Thank you to all the staff for the excellent care you provided to my dad, even when he was challenging, you all deserve a medal.

Major trauma accident at work leading to 7 months in hospital - 536 views

Posted by lyrans97 a service user

I was seriously injured at my work last year. I was crushed by a concrete ceiling so I suffered a broken femur, broken pelvis, broken hip, dislocated shoulder, broken bones in face spine and torso. Also had severe chemical burns all over my body in particular my left arm. I was trapped under it and the pain I felt was unbelievable at the time, almost sending me into an immediate dream with the adrenaline. The boys I worked with first and foremost found me and helped immensely but I cannot speak highly enough of the emergency services who attended the scene and then managed to safely get me out, hose the cement off my body as best they could and then managed to somehow stable me enough to take me to the ERI.

I was in a terrible state, literally fighting for my life, but the service I got which saved my life I could not speak highly enough about. I was put in an induced coma ICU and the team working with me saved my life. They saved my eyesight by continually putting drops in and cleaning them. I got surgery to repair all my broken bones and then as the days went by I was more stable. They monitored everything exceptionally well, I had skin grafts done and was taken to St Johns. The burns were flushed and monitored as well as being woken up out of sedation. I had delirium and the nurses were amazing working with me to keep me calm and let me naturally come round whilst proving very good care and talking with family.

I was then transferred to the Vic in Kirkcaldy Ward 33. This allowed my body time to recover and rest. The team there gave me again excellent care, they were very good at working around my needs as I was bed bound and I was extremely sore and uncomfortable. They always checked in to see how I was along with visitors and made me feel safe again as going through the trauma I had, it was hard to feel safe and relaxed anywhere. I was put forward for physio and they got me out the bed into chairs using equipment and got me motivated to get better and see the long term goals that I wanted to set.

Finally I was transferred to the Queen Margaret ward 5 in Dunfermline. In my 4 months there I came on so much, the staff were truly unbelievable to me. They picked me up when I was down, kept me positive. They looked after me with the correct medication and just the all-round general care was very very good. The staff were good at identifying any issues small or large that I may have had and they were just all round top people. The communication was very good which I was happy with and the kindness to family was great.

The physio team got me first into using aids, up on my feet and week by week I progressed reaching targets and aims set by the occupational therapy team who were also very good to me. They identified aims, they helped me with the practical basics in life and also got me the psychological help required, because as time went by I felt worse about being contained to a hospital. The physio also got my confidence up and helped reduce pain by intense stretching exercises, walking longer distances and helping me meet my goals such as being able to look after and get my bond back with my daughter. I did lots of weight training and strengthening and conditioning work, balance work and continuously walking to improve the pattern.

Then the major trauma pathway team, everyone I worked with were very good with passing information on and also looking at the best options for me. I have been discharged now and will continue to rehab with physiotherapy, plastic surgery appointments, ICAAS team and psychology. Major trauma link coordinator and my GP will also be involved with any follow up/checkup appointments.

The staff all round at Queen Margaret even the charge nurses, everyone involved in my care, made me feel as at home as possible and did everything they could to help me physically and mentally continue to recover and I am so thankful for that.

Overall I am eternally grateful for the care, help, support and work put in to get me in a position to go back home and start life again. I have a long way to go but to be up on my feet is a blessing. I put in so much hard work in this recovery but without the incredible service and staff of the NHS along the way, none of this would be possible. So thank you, I am forever blessed to have met such important people to me and my family now with the chance of a good quality of life again.

Thank you so much,

An important aspect of Care Opinion is the ability to feedback information to patients on **changes** which have been made. **Recent changes**, following patient feedback, includes:

Cataract Unit, Queen Margaret Hospital

- Look into providing drinks following surgery

Gynaecology, Queen Margraet Hospital

- Work underway to make the current reception process more comfortable foe people to attend clinics

National Treatment Centre, Victoria Hospital

- Looking at solutions including a mounting a standard toilet roll onto one of the drop handles on either side of the disabled toilet which is easily reachable for the user
- Look into the potential for clearer directions for the shortest and easiest way to get from the bus stops to the NTC

Compliments:

Compliments are another vital component of patient feedback. There is a 'compliments' section in the Datix Complaints module which is not widely used, and the following table only provides a small glimpse of positive patient feedback.

It is hoped that the 'compliments' module will become more widely used as staff are encouraged to record compliments, celebrating and learning from success.

Compliments	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Compliments	296	320	277	263	1156
Learning from Excellence (Greatix)	0	0	0	0	0
Comments and Feedback	3	0	0	0	3
Total	299	320	277	263	1159

Compliments	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Planned Care & Surgery	126	138	127	76	467
Emergency Care & Medicine	30	36	37	32	135
Women Children & Clinical Services	23	5	10	40	78
Community Care Services	70	43	59	37	209
Primary and Preventative Care	22	29	27	27	105
Complex and Critical Care Services	9	13	7	6	35
Corporate Directorates	1	0	1	0	2
No value – Miscellaneous	15	56	9	45	125
Total	296	320	277	263	1156

Comments:

Emergency Care & Medicine - I would like to compliment both the Victoria hospital, I think Ward 53 and St Andrews hospital Ward 1 for the excellent care and attention given to my husband during his lengthy stay there. Staff have been so kind to him and me and to my family by allowing us to sleep over at times, bringing us cups of tea and comforting me after my husband passed. No words can explain my thanks to them.

Community Care Services Older Peoples' Services – Just wanted to say, 'Thank You'. Thanks for being wonderful! To all the amazing staff at Balgonie Ward, thank you so much for your excellent care and support. You are all marvelous! I can't actually thank you enough.

Woman and Children's – I wanted to pass on some feedback of PAU and Children's Ward. My little Giorgia was admitted septic recently requiring triple therapy. Thankfully on the mend now. I wanted to pass on how amazing the staff had been looking after her and how I genuinely could not fault the service and patient care we received. Some staff went above and beyond, two female doctors, Sonya and Ayla and Staff Nurse Catherine who was Giorgia's named nurse. The whole team are a credit to the service.

Complaints:

Trends

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution

The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.

Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation

Complaints might be handled at stage 2 because:

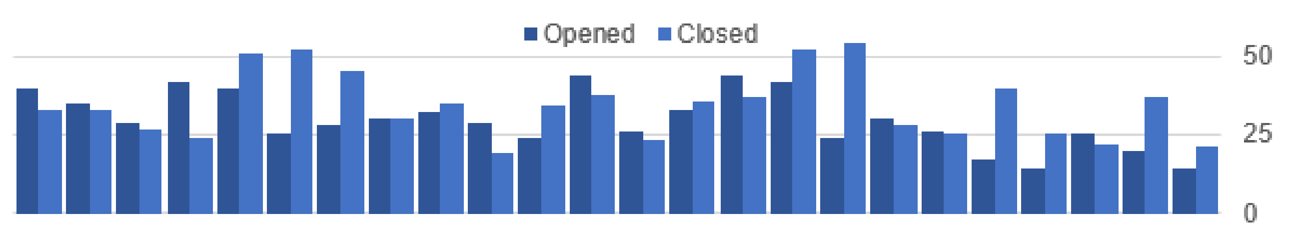
- They are complex, serious or high-risk issues and are not suitable for early resolution
- Early resolution has failed
- The complainant was unhappy with the outcome of stage 1 and asked for an investigation

The complainant should receive a written response within 20 working days.

This table presents the total number of Enquiries, Concerns, Stage 1 and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 010422-310323	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Stage 1 Complaint	151	139	129	113	532
Stage 2 Complaint	102	87	56	65	310
Concern	124	131	121	241	617
Enquiry	189	210	163	131	693
Total	566	567	469	550	2152

Stage 2	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total	23	33	37	44	51	25	24	39	23	22	36	21
Closed within timescales	6	3	6	4	4	2	6	4	1	2	5	3
% Closed within timescales	26.1%	9.1%	16.2%	9.1%	7.8%	8.0%	25.0%	10.3%	4.3%	9.1%	13.9%	14.3%



Themes

The quarterly ranking of each theme is highlighted in brackets.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4
1	Disagreement with treatment / care plan (26)	Co-ordination of clinical treatment (39)	Co-ordination of clinical treatment (49)	Disagreement with treatment / care plan (30)
2	Co-ordination of clinical treatment (11)	Disagreement with treatment / care plan (23)	Disagreement with treatment / care plan (44)	Co-ordination of clinical treatment (19)
3	Face to face (5)	Staff attitude (18)	Staff attitude (31)	Face to face (11)
4	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (12)	Unacceptable time to wait for the appointment / admission (15)	Lack of clear Explanation (8)
5	Staff attitude (4)	Poor nursing care (11)	Insensitive to patient needs (13)	Staff attitude (8)

The top 4 themes are:

- Coordination of clinical treatment (123)
- Disagreement with treatment / care plan (118)
- Face to face (61)
- Poor nursing care (27)

Positive and Negative Themes

Positive themes (Care Opinion)	Negative Themes (Care Opinion)	Negative Themes (Complaints)
Staff	Communication	Disagreement with treatment / care plan
Professional	Not being listened to	Staff attitude
Friendly	Waiting time/s	Co-ordination of clinical treatment
Nurse	Staff attitude	Unacceptable time to wait for the appointment
Communication	Appointments	Face to face
Caring	Access to services	Telephone
Level of care	Beside manner	Lack of support

Locations receiving most complaints:

1. Emergency Department, Victoria Hospital
2. Methilhaven Medical Practice
3. Admissions Unit 1 (AU1), Victoria Hospital
4. Ward 53, Victoria Hospital
5. Outpatients, Phase 2, Victoria Hospital

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

ARTC Leaflets

Awaiting further information

Care Experience Improvement Model (CEIM)

CEIM is a simple framework that supports health and social care teams to make improvements directly related to feedback in a person-centred way.

Awaiting further information

Physiotherapy Service

The Physiotherapy services within Fife introduced a patient/carer questionnaire about transition between children and young people Physiotherapy team and the adult learning disability Physiotherapy team. The feedback highlighted that the transition from children to adult physiotherapy services continued to be a negative experience for children and their families, especially those with a diagnosed learning disability and long-term health needs. There was already a well-established transition pathway, but it tended to happen in final year of school. All clinicians involved in the project agreed the process could be more efficient, allowing a more positive experience for patients and their families. Evidence from other areas suggests that an earlier transition from the age of sixteen could help reduce anxiety and improve the overall transition process and experience. This was especially the case for young adults with a diagnosed learning disability. The results of this project led and feedback from patients and families led to a test of change with an alternative transition pathway for these young adults.

Children and young people's Physiotherapy service also introduce a parent advice line, established as part of the Ready to act. It aims to make services more accessible and fits the waiting well agenda. Patient feedback from users of the advice line was also sought to help develop the new project.

Questions that Matter Form

Questions that Matter Form that incorporates BRAN (Benefits, risks, alternatives, and do nothing) has been developed for patients which includes the Fife derived question: 'what else can I do to help myself?'. QR code developed and embedded in patient letters for easy access.

Improving access to NHS Fife services for British Sign Language user

NHS Fife has a statutory responsibility to ensure people who use British Sign Language (BSL) can access services. Historically, external companies to provide BSL interpretation services have been used, however feedback from patients and staff was that this service was no longer meeting their needs.

A review of BSL provision was undertaken to identify how improvements could be made to access services for patients and staff. The review gathered a range of data on the use of the service, feedback from patients and staff.

In January 2023 NHS Fife appointed its first dedicated British Sign Language (BSL) interpreter to help improve the experience for Deaf BSL users attending hospitals in Fife. A qualified BSL interpreter and took up the role within NHS Fife's Patient Experience Team in January 2023.

BSL interpreters are already widely used in the NHS in Scotland. Most often interpreters are contracted in to provide services as required, which can be costly and time consuming. The appointment of NHS Fife's first dedicated BSL interpreter means that access for BSL users can be much more flexible and responsive to their needs, while also delivers a cost saving at a time when NHS resources are stretched.

The BSL interpreter works with Deaf BSL users and staff across all healthcare services within acute and community hospitals along with GP practices and even home visits across Fife. Supporting conversations between patients and clinicians and helping ensure that the views of patients are understood. The BSL interpreter will also be signing written communications to patients in advance of

clinical procedures to ensure that any information is delivered clearly in the patient's preferred language.

In addition to working with patients, the BSL interpreter will also be available for current and prospective healthcare staff who use BSL, including at staff meetings, training and for job interviews.

There are many benefits including, increased availability for interpretation at short notice or emergency appointments, greater uptake of BSL interpretation including by patients who have previously avoided accessing services due to poor interpretation support, positive feedback from patients and staff using the service, and availability for patients to access the interpreter for help with rescheduling or planning appointments via video call.

Staff member* – *"Was not an easy process before. Now is much better by a country mile!"

Patient* – *"Great for Fife… [the interpreter] was with me and my wife last Friday… at our GP [appointment]"!"

The provision of an in-house interpreter has helped to reduce the barriers to accessing our services which in time will contribute to improved health and wellbeing for the Deaf-BSL Community using our services. Our BSL interpreter has also been able to support staff working in NHS Fife who communicate using sign language and has supported job interviews. There are opportunities in the future to support 1-1 meetings and appraisals in the future. We are demonstrating how we can be an exemplar employer in line with our Anchor Ambitions supporting all parts of our community to access employment with NHS Fife.

The BSL Interpretation Service are currently evaluating the impact of our in-house interpreter service and will take forward next steps in summer 2024.

Patient and family feedback regarding Model Complaint Handling Procedure

An electronic feedback form is used to enhance the complaint process experience for complainants. It enables patients to provide immediate responses post-complaint resolution and is distributed via Microsoft Forms or a paper version if preferred. The form is designed to capture the patient's experience, ensuring a streamlined and accessible feedback mechanism. By prioritising patients' insights, the aim is to create a more transparent and responsive complaint handling system that fosters a sense of engagement and trust.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	2023/ 2024
New SPSO cases	3	13	4	5	25	8	7	8	7	30
SPSO decisions	6	4	1	3	14	5	0	3	1	9
SPSO cases upheld	1	1	0	1	3	1	0	2	1	4
SPSO cases partly upheld	3	2	N/A	N/A	5	N/A	N/A	N/A	N/A	N/A
SPSO cases not upheld	2	1	1	2	6	1	0	1	0	2
Cases not taken forward	6	1	1	0	8	3	0	1	6	10

SPSO Investigation Reports and Decision Reports published on SPSO website, April 2023 to March 2024:

INVESTIGATION REPORTS	
No.1 SPSO Ref No.	202105840
Month	December 2023
Themes	Care and Treatment; Complaint handling
Outcome	Upheld with 5 Recommendations
Location	VHK – DVT Clinic; Ward 42
Findings	1. There was a failure to appropriately review and monitor C's platelet count at the DVT clinic. 2. There was a failure to appropriately assess and diagnose C for suspicion of Heparin Induced Thrombocytopaenia (HIT); provide appropriate haematology advice to medical staff and review and document C's response to pain relief. 3. The Board's handling of C's complaint was unreasonable including their handling of the LAER.
Recommendations	1. Apologise to C for the failings identified in this report. 2. Bloods results should be appropriately reviewed and patients receiving heparin injections appropriately monitored. Patients should receive appropriate, timely review if any new onset symptoms are reported.

	3. Patients presenting symptoms as in C's case should be appropriately reviewed by general and speciality medical staff with reference to the timeframe of onset of symptoms and likely manifestations of HIT, such as stroke, with treatment commenced as appropriate. 4. When an incident occurs that falls within the Duty of Candour legislation, the Board's Duty of Candour processes should be activated without delay and the individual notified within the prescribed timescales. 5. Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. The Board's adverse event policy should be consistent with HIS guidance, and the type of investigation undertaken should be appropriate to the level of category identified. Recommendation – action already taken: The outcome of the local adverse event review had been shared with the key individuals involved for reflection and learning to include improvement in documentation.
Actions	Evidence was submitted to the SPSO, and the complaints reviewer confirmed on 13 February 2024, that all recommendations had been evidenced, with the exception of recommendation 5, part two, which has a deadline of 26 March 2024, and is in relation to the Adverse Events policy.

DECISION REPORTS	
No.1 SPSO Ref No.	202100730
Month	October 2023
Themes	Clinical Treatment; Diagnosis
Outcome	Upheld with Recommendations
Location	VHK OMFS
Recommendations	Offer apology to complainant for failing to reasonably assess and diagnose A's dislocated jaw; findings fed back to staff to inform future decision-making regarding assessment process; referral seen within reasonable timescale. Complaint process – processes should be followed to ensure reporting and learning
Actions	Action plan completed; evidence submitted to SPSO

INVESTIGATION REPORTS	
No.1 SPSO Ref No.	202201215
Month	February 2024
Themes	Poor care
Outcome	3 points upheld / 1 point not upheld with 7 Recommendations and Feedback to NHS Fife Board

Location	QMH – Palliative Care Inpatients
Findings	4. There was a failure to manage A's wounds appropriately. 5. There was a failure to respond to A's fall appropriately. 6. There was a failure to manage A's pain appropriately.
Recommendations	6. Apologise to C for the failings identified in this report. 7. Patients should receive care as required and prescribed in care rounding bundles. Those requiring would care should be appropriately managed in line with local and national guidance on wound management. 8. Nursing staff should be competent in the accurate completion of falls documentation. 9. Patients should receive appropriate pain management including regular structured assessment of their pain, e.g., through the use of a structured pain management assessment toll or chart. This should be documented. Patients should receive appropriate medical review on escalation and reviewed should be carried out promptly. 10. The Board's complaint handling monitoring, and governance system should ensure that complaints are properly investigated and responded to; are accurate, timely, and that failings and good practice are identified. 11. The Board said that staff had completed an online learning module 'check, Protect, refer for feet', and the podiatry team are implementing face-to-face training sessions to staff in community hospitals. 12. Staff will complete an online learning module on pain. **Feedback for Fife NHS Board** If required multiple enquiries to obtain complete information requested as part of the initial enquiry. It also appears the Board provided new records when responding to the provisional decision; all records should have been provided in response to the initial enquiry and notification of investigation. The case was escalated to Level 2 under SPSO's Support and Intervention Policy due to the Board's delay in providing information in response to our notification of investigation. **Points to note** The medical adviser commented that the Board's analgesia protocol for patients aged 70 years and older who have sustained a fragility fracture could include warnings about dose reduction if patients have a kidney impairment. I am highlighting this here for the Board's consideration. Recommendations – all complete and SPSO have marked all actions for the recommendations on the investigation as complete (12/04/2024)
Actions	No further actions required.

NHS Scotland Model Complaints Handling Procedure

Empowering people to be at the centre of their care and listening to them, their carers and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- To take a consistently person-centred approach to complaints handling across NHS Scotland.
- To implement a standard process.
- To ensure that NHS staff and people using NHS services have confidence in complaints handling.
- Encourage NHS organisations to learn from complaints in order to continuously improve services.

Complaints Performance Indicators

The CHP introduced nine key performance indicators by which NHS Boards and their service providers should measure and report performance. These indicators, together with reports on actions taken to improve services as a result of feedback, comments and concerns will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

Quarterly Reports

In accordance with THE PATIENT RIGHTS (FEEDBACK, COMMENTS, CONCERNS AND COMPLAINTS (SCOTLAND) DIRECTIONS 2017 (the 2017 Directions) relevant NHS bodies have a responsibility to gather and review information from their own services and their service providers on a quarterly basis in relation to complaints. Service providers (Primary Care) also have a duty to supply this information to their relevant NHS body as soon as is reasonably practicable after the end of the three-month period to which it relates.

This quarterly report represents NHS Fife's response to the 2017 Directions and will form part of the Feedback and Complaints Annual Report for the Scottish Government. This section of the report is structured around the nine Key Performance Indicators.

Indicator One: Learning from complaints

- *A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:*

- *An action plan recommended by the SPSO highlighted a failure to use a proper lifting technique after a patient fall with a suspected hip injury. It is advised that staff be aware of the need to assess potential fractures and use safe manual handling procedures for possible fractures, including the*

use of flat lift equipment. Training needs for safe manual handling have been reviewed according to national guidance. Lateral Lifters are being purchased for various departments within the organisation.

- *Within Datix, there is now a function to link the complaints module to the incident module, ensuring that learning from both is connected.*

- *The Patient Experience Team is collaborating with the Adverse Events Team and other services to streamline processes when complaints and adverse events are related. This aims to ensure that both processes, while separate, work together to provide a better person-centred approach, with the goal of improving communication and the overall experience for complainants, patients, and their families.*

- *The Urology Service recently received feedback from a patient who underwent a new procedure called the temporarily Implanted Nitinol Device (iTIND). This procedure is a minimally invasive treatment that gently reshapes the urethra, widening the opening through which urine can flow. After consulting with the Senior Charge Nurse and the operating Urology Consultant, it was decided that in addition to showing the patient a video during the consultation process, an information leaflet would also be provided for the patient to take home. Furthermore, a post-operative leaflet was created to guide patients on what to expect after the procedure. Additional post-operative medication will be provided to help reduce any pain or discomfort that may be experienced in the days following the procedure. A pre-medication will also be provided on the morning of the procedure. Additionally, there was consideration for implementing a post-operative check at day 3 or 4 with the patient. Meanwhile, patients are provided with a point of contact should they experience any issues prior to the post-operative appointment, which occurs one week after the procedure.*

- *The Patient Experience Team works collaboratively with the Adverse Events Team to streamline processes when complaints and adverse events are linked. This will ensure that both processes, although separate and working together to provide a better person-centred focused approach, aim to improve communication and overall complainant/patient/family experience. A draft flow chart has been created to map the proposed process.*

- *A patient expressed dissatisfaction with the care received in an outpatient area and felt that their concerns were not adequately addressed before going home. As a result, the patient had to be admitted overnight. In response to the complaint, the Senior Charge Nurse and Clinical Nurse Specialists are collaborating with the Practice and Professional Development team to update the training and competency framework to ensure it is comprehensive and current. Additionally, the Urology team is reviewing the monitoring of competency skills within the department."*

- *A patient and their family were hesitant to raise their concerns with the ward staff or the Patient Experience Team for support. The Senior Charge Nurse has now established a board within the ward to promote the use of patient feedback and to foster an open and safe culture that encourages feedback. This initiative provides an opportunity to identify and address areas for improvement, as well as to share positive feedback from patients, families, and caregivers. Additionally, education sessions for staff on Tissue Viability will be organised.*

- *A family faced challenges when a patient's wound needed suctioning and a dressing change. The Senior Charge Nurse (SCN) acknowledged that the nursing staff on the ward had different levels*

of experience and skill in caring for complex wounds. The SCN has scheduled training and education sessions with Tissue Viability to address this issue.

- *A family encountered difficulties with their sister's stoma care. The SCN has arranged for training and education sessions with the Stoma Team.*

- *Following several incidents and complaints relating to the failures in the handover of care from acute to community settings, a new Short Life Working Group (SLWG) was created to look at developing pathways for the discharge of patients from the acute setting.*

- *A cancer diagnosis and treatment were delayed due to the failure to consider cancer as an underlying diagnosis at the outset of the patient's presentation. It was identified that earlier intervention may have avoided the difficulties the patient faced with ongoing abdominal pain, repeated hospital admissions and a delay to their surgical treatment. As a result of this complaint and Significant Adverse Event Review (SAER), discussion and learning has taken place with the wider General Surgery Team to ensure clinicians have a robust process in place to manage additional information from Radiology and for this to be communicated with their patients.*

Indicator Two: Complaint Process Experience

To Enhance the complaint process experience for complainants an electronic feedback form is used which enables patients to provide immediate responses post-complaint resolution. This form is distributed via Microsoft Forms or a paper version if this is the complainants preference and is designed to capture the patients experience, ensuring a streamlined and accessible feedback mechanism. By prioritising patients' insights, the aim is to create a more transparent and responsive complaint handling system that not only acknowledges their concerns but also fosters a sense of engagement and trust.

The data collected from these feedback forms is reviewed regularly by the Patient Experience Team. This consistent review process allows us to identify trends, pain points and areas for improvement within the complaint handling procedure. The insights gained are instrumental in driving changes where necessary, thus enhancing the overall patient experience. By employing this proactive approach, not only are individual complaints more effectively addressed but also works towards pre-emptively managing potential issues, creating a culture of continuous improvement and commitment to excellence in patient care.

- *All correspondences have been reviewed with a focus on tone, language, and overall clarity to ensure that they are always compassionate, empathetic, and easily understood. This ensures that communication is more patient-friendly, prioritizing key information that is important to them and making it clear what actions, if any, are required. These small changes reflect the commitment to patient-centred care, ensuring that communication is not only informative but also always respectful and considerate of patient and family needs.*

- *Although aware of the emotional impact of patients receiving complaint communications during sensitive times, a review of the complaint handling process and timings took place as a broader commitment to being more mindful and responsive to the emotional well-being of patients and their families, ensuring that processes are as considerate as possible.*

Indicator Three: Staff Awareness and Training

Subject Title	No. of staff	Notes
Good conversations (GC)	69	Figures provided for NHS, Social work / Fife Council, Voluntary Sector
GC Foundation Management	32	Good Conversations training is also provided as a half-day session on the 5-day Foundation Management programme
Adverse Events	-	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Duty of Candour	526	
Root Cause Analysis	-	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.
Human Factors	7	NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters. We are unable to report on engagement in these resources.

Indicator Four: The total number of complaints received

4a. Number of complaints received by the NHS Fife Board	980
4b. Number of complaints received by NHS Primary Care Service Contractors	204
4c. Total number of complaints received in the NHS Board area	**1184**

NHS Fife Board - sub-groups of complaints received

NHS Board managed Primary Care services:	
4d. General Practitioner	25
4e. Dental	4
4f. Ophthalmic	0
4g. Pharmacy	**0**
Total - Board managed Primary Care services	**29**

Independent Contractors - Primary Care services:	
4h. General Practitioner	309
4i. Dental	19
4j. Ophthalmic	0
4k. Pharmacy	84
Total – Independent Contractors	**412**
4l. Combined total of Primary Care Service complaints	**441**

Indicator Five: Complaints closed at each stage

Number of complaints closed by the NHS Board *(do <u>not</u> include contractor data, withdrawn cases or cases where consent not received).*	**Number**	**As a % of all NHS Board complaints closed (not contractors)**
5a. Stage One	544	78%
5b. Stage two – non escalated	126	18%
5c. Stage two - escalated	30	4%
5d. Total complaints closed by NHS Board	**700**	**100%**

Indicator Six: Complaints upheld, partially upheld and not upheld

Stage one complaints	**Number**	**As a % of all complaints closed by NHS Board at stage one**
6a. Number of complaints upheld at stage one	278	48%
6b. Number of complaints not upheld at stage one	203	35%
6c. Number of complaints partially upheld at stage one	98	17%
6d. Total stage one complaints outcomes	**579**	**100%**

Stage two complaints **Non-escalated complaints**	**Number**	**As a % of all non-escalated complaints closed by NHS Boards at stage two**
6e. Number of non-escalated complaints **upheld** at stage two	32	21%
6f. Number of non-escalated complaints **not upheld** at stage two	73	53%
6g. Number of non-escalated complaints **partially upheld** at stage two	37	26%
6h. Total stage two, non-escalated complaints outcomes	**142**	**100%**

Stage two escalated complaints **Escalated complaints**	**Number**	**As a % of all escalated complaints closed by NHS Boards at stage two**
6i. Number of escalated complaints **upheld** at stage two	5	18%
6j. Number of escalated complaints **not upheld** at stage two	26	70%
6k. Number of escalated complaints **partially upheld** at stage two	5	12%
6l. Total stage two escalated complaints outcomes	**12**	**100%**

Indicator Seven: Average times

7a. the average time in working days to respond to complaints at stage one	10
7b. the average time in working days to respond to complaints at stage two	44
7c. the average time in working days to respond to complaints after escalation	56

Indicator Eight: Complaints closed in full within the timescales

	Number	**As a % of complaints closed by NHS Boards at each stage**
8a. Number of complaints closed at stage one within 5 working days.	248	76%
8b. Number of non-escalated complaints closed at stage two within 20 working days	34	16%
8c. Number of escalated complaints closed at stage two within 20 working days	10	8%
8d. Total number of complaints closed within timescales	**292**	**100%**

Indicator Nine: Number of cases where an extension is authorised

	Number	**As a % of complaints closed by NHS Boards at each stage**
9a. Number of complaints closed at stage one where extension was authorised	112	70%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	50	30%
9c. Total number of extensions authorised	**162**	**100%**

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

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

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

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

Executive Summary:

- The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2017(the "2017 Directions") (Direction 15), set out that NHS Boards must publish annual reports and send copies to the Scottish Ministers, the PASS, Healthcare Improvement Scotland, SPSO, and, where appropriate, the Scottish Prison Service by 30 June each year.

- The Directors Letter DL (2024) 16 advises Chief Executives that the deadline for submission of NHS Complaints and Feedback Annual reports has been extended from 30 June 2024 to 30 September 2024. This is a permanent change such that the deadline will be 30 September each year going forward.

- In recognition of the challenges and additional pressures faced by NHS Boards since the start of, and during the NHS recovery from the pandemic, 30 September was used informally as an alternative.

- The National Complaints Personnel Association Scotland (NCPAS) has consistently advised that the timescale of 30 June proves to be unrealistic with the level of clearance required before annual reports can be finalised

- The Scottish Government has listened to this feedback indicating a permanent change to the timescale for submission of annual reports to later in the year would be welcome.

- The Quarterly Patient Experience and Feedback reports, presented to the Clinical Governance Committee, are based on the template used to capture the required information for return to HIS, NSS, Scottish Government and for publication on NHS Fife's website.

1 Purpose

The purpose of this paper is to provide an overview of the Patient Experience and Feedback Annual Report, which requires approval by Fife NHS Board before publication on NHS Fife website.

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Government policy / directive
- NHS Board Strategic Priority/ies – To Improve Quality of Health & Care Services

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

- Person Centred

2 Report summary

2.1 Situation

The Annual Report must be published by 30 September each year.

2.2 Background

The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2017(the "2017 Directions") (Direction 15), set out that NHS Boards must publish annual reports and send copies to the Scottish Ministers, the PASS, Healthcare Improvement Scotland, SPSO, and, where appropriate, the Scottish Prison Service by 30 June each year.

In recognition of the challenges and additional pressures faced by NHS Boards since the start of, and during the NHS recovery from the pandemic, 30 September was used informally as an alternative. This is a permanent change such that the deadline will be 30 September each year going forward.

2.3 Assessment

The Patient Experience and Feedback Annual Report for NHS Fife reflects a comprehensive analysis of the key performance indicators (KPIs) related to the Model Complaints Handling Procedure. The data, presented in the quarterly reports regularly presented to the Clinical Governance Committee, indicates consistent engagement with feedback mechanisms, including complaints, compliments, Care Opinion, and the Scottish Public Services Ombudsman (SPSO).

The report highlights trends in patient feedback, identifying areas where improvements have been made and where challenges persist. Positive feedback through Care Opinion

and compliments has also been evident, reflecting the quality of care provided across services. The insights provided will inform ongoing strategies to enhance patient experience and ensure robust governance of feedback processes.

This report provides the following Level of Assurance: (add an 'x' to the appropriate box)

	Significant	Moderate	Limited	None
Level	x			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Ensuring healthcare delivery is aligned with patient needs and values, achieving the best possible health outcomes that matter to patients rather than merely providing services, ultimately leads to better health outcomes and value-based care. Measuring success based on patient satisfaction and experience can ensure that the care provided aligns with patient expectations and improves their quality of life.

By analysing data from patient experience feedback, NHS Fife can make informed decisions to enhance the quality of care and services.

2.3.2 Workforce

n/a

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk as it enables the organisation to address issues proactively, improve services, communicate transparently, build trust, comply with regulations, and foster a culture of continuous improvement. Actively contributing to a positive reputation and a stronger more resilient organisation.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement, and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

This paper is provided to members for a **"significant"** level of assurance.

3 List of appendices

- Appendix 1 - Annual Report on Feedback and Complaints Performance Indicator Data collection 2023-2024

Report Contact
Siobhan McIlroy
Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

NHS Fife

Annual Report on Feedback and Complaints Performance Indicator Data collection 2023-2024

Performance Indicator Four:

4. Summary of total number of complaints received in the reporting year

4a. Number of complaints received by the NHS Territorial Board or NHS Special Board Complaints and Feedback Team	**980**
4b. Number of complaints received by NHS Primary Care Service Contractors (*Territorial Boards only)*	**204**
4c. Total number of complaints received in the NHS Board area	**1184**

NHS Board - sub-groups of complaints received

NHS Board managed Primary Care services;	
4d. General Practitioner	**25**
4e. Dental	**4**
4f. Ophthalmic	**0**
4g. Pharmacy	**0**
Total - Board managed Primary Care services (this total should be included in 4a)	**29**
Independent Contractors - Primary Care services;	
4h. General Practitioner	**215**
4i. Dental	**18**
4j. Ophthalmic	**0**
4k. Pharmacy	**69**
Total – Independent Contractors (this total should be entered at 4b)	**331**
4l. Combined total of Primary Care Service complaints	**360**
4m. Total of prisoner complaints received *(Boards with prisons in their area only)* **Note: Do not count complaints which are unable to be concluded due to liberation of prisoner / loss of contact.**	**N/A**

Performance Indicator Five

5. The total number of complaints closed by NHS Boards in the reporting year *(do not include contractor data, withdrawn cases or cases where consent not received).*

Number of complaints closed by the NHS Board	Number	As a % of all NHS Board complaints closed (not contractors)
5a. Stage One	544	78%
5b. Stage two – non escalated	126	18%
5c. Stage two - escalated	30	4%
5d. Total complaints closed by NHS Board	**700**	100%

Performance Indicator Six

6. Complaints upheld, partially upheld and not upheld

Stage one complaints

	Number	As a % of all complaints closed by NHS Board at stage one
6a. Number of complaints upheld at stage one	278	48%
6b. Number of complaints not upheld at stage one	203	35%
6c. Number of complaints partially upheld at stage one	98	17%
6d. Total stage one complaints outcomes	**579**	100%

Stage two complaints

Non-escalated complaints	Number	As a % of all complaints closed by NHS Boards at stage two (non-escalated)
6e. Number of non-escalated complaints upheld at stage two	32	23%
6f. Number of non-escalated complaints not upheld at stage two	73	51%
6g. Number of non-escalated complaints partially upheld at stage two	37	26%
6h. Total stage two, non-escalated complaints outcomes	**142**	100%

Stage two escalated complaints

Escalated complaints	Number	As a % of all escalated complaints closed by NHS Boards at stage two
6i. Number of escalated complaints upheld at stage two	5	14%
6j. Number of escalated complaints not upheld at stage two	26	72%
6k. Number of escalated complaints partially upheld at stage two	5	14%
6l. Total stage two escalated complaints outcomes	**36**	100%

Performance Indicator Eight

8. Complaints closed in full within the timescales

This indicator measures complaints closed within 5 working days at stage one and 20 working days at stage two.

	Number	As a % of complaints closed by NHS Boards at each stage
8a. Number of complaints closed at stage one within 5 working days.	248	85%
8b. Number of non-escalated complaints closed at stage two within 20 working days	34	12%
8c. Number of escalated complaints closed at stage two within 20 working days	10	3%
8d. Total number of complaints closed within timescales	**292**	100%

Performance Indicator Nine

9. Number of cases where an extension is authorised

This indicator measures the number of complaints not closed within the CHP timescale, where an extension was authorised* .

	Number	**As a % of complaints closed by NHS Boards at each stage**
9a. Number of complaints closed at stage one where extension was authorised	112	69%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	50	31%
9c. Total number of extensions authorised	**162**	100%

***Note:** The SPSO confirm that there is no prescriptive approach about who exactly should authorise an extension – only that the organisation takes a proportionate approach to determining an appropriate senior person – and this is something that NHS Boards should develop a process for internally. This indicator aims to manage the risk of cases being extended beyond the CHP timescale without any senior officer approval.

Completed by:

Name: Siobhan Mcilroy	**Position: Head of Patient Experience**
Tel: 01592 648154	**E-mail: Siobhan.mcilroy@nhs.scot**
Date:	

E-mail completed template to: nhscomplaintsreports@gov.scot

By:

For any queries on completion, please contact:
Linda Kirk, Scottish Government
e-mail: linda.kirk@gov.scot

NHS Fife

Meeting: **Clinical Governance Committee**

Meeting date: **6 September 2024**

Title: **Advanced Practitioners Review Update**

Responsible Executive: **Janette Keenan, Director of Nursing**

Report Author: **Mairi McKinley, Head of Practice and Professional Development**

Executive Summary:

- Further to the report presented to CGC in May 2023, an update on the progress of the development of Advanced Nurse Practitioners (ANPs) is provided for assurance.

- The environment in which ANPs work remains complex and demanding. To meet the needs of services, the ANP must work across all four pillars of advanced practice and there are many examples of the impact of having ANPs delivering care, improving the experience of patients receiving timely, high quality and person-centred care.

- Workforce Data:

Workforce Data	ASD Band 8	ASD Band 7	HSCP Band 8	HSCP Band 7
2024	5	44.54	4	32.73

- In 2023, the intent was to ensure that all ANPs met the 10% protected Non-Clinical Time (NCT) requirement in their job plans to enable delivery of the 3 remaining pillars of practice. Despite significant work, this is still not being achieved in most services.

- Whilst there is now an ongoing CPD programme for all Advanced Practitioners to access, variation still exists in clinical supervision for ANPs.

- The establishment of the Advanced Practice Council this year will enable the development of the AP Policy and Strategic Framework. Once implemented, the policy and framework, along with the implementation of the national Clinical Supervision Framework will minimise the risk across the organisation by ensuring a standardised approach to job plans including NCT

- Due to the complexities and variations within the ANP role, on 27 March 2024, the Nursing and Midwifery Council (NMC) approved the recommendation that they proceed to develop an approach to the additional regulation of advanced practice.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Further to the report presented to EDG on 20 April 2023, an update on the progress of the development of Advanced Practice (AP) roles in NHS Fife and the HSCP, specifically Advanced Nurse Practitioners (ANPs) is provided for consideration. The anticipated publication of a Scottish Government Transforming Roles (TR) for Advancing Practice in the Allied Health Professions (AHPs) in 2022 has not materialised; therefore, this paper focuses on ANPs whilst awaiting publication of the TR AHP paper.

2.2 Background

In May 2022, a permanent Senior Practitioner (Practice and Professional Development (PPD)) Advanced Practice was appointed. In 2023, a fixed term secondment post of 0.4 FTE Lead Facilitator (PPD) Advanced Practice was established to assist in the ongoing implementation of the guidance published in CNOD Advanced nursing practice - transforming nursing roles: phase two paper[1], progress NMaHP AP governance and assurance across the organisation and facilitate the publication of the AP toolkit and the establishment of an AP forum.

Due to the complexities and variations within the ANP role, on 27 March 2024, the Nursing and Midwifery Council (NMC) approved the recommendation that they proceed to develop an approach to the additional regulation of advanced practice. The NMC will undertake wider stakeholder engagement and public consultation, but it is likely that advanced level practice requirements are included in the wider reviews of revalidation and the Code scheduled for 2025/26.

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

2.3 Assessment

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

A significant amount of work was undertaken in 2022-23 to standardise the implementation, governance and assurance of ANP roles across Fife. Whilst this work is fully embedded in some services, it is not consistent throughout Fife.

2.3.1 Quality, Patient and Value-Based Health & Care

The environment in which ANPs work remains complex and demanding. Within Fife, ANPs work in all Directorates and many services including Neonatal and Paediatrics; Mental Health; Urgent Care; Community and GP practices; and Acute services. To meet the needs of these services, the ANP must work across all four pillars of advanced practice and there are many examples of the impact of having ANPs delivering care now improves the experience of patients receiving timely, high quality and person-centred care.

In areas such as the NTC, the ANP led service delivers high quality and effective care with a focus on optimising the in-patient experience with discharge and follow up processes also undertaken by ANPs. Working in collaboration with medical and pharmacy colleagues, the ANPs have reduced unwarranted variation in care delivery and have embedded the work of the High-Risk Pain Medicines (HRPM) programme to reduce harm and waste associated with pain medicines whilst still supporting shared decision making and a personalised approach for patients. The benefits of these approaches have been highlighted in patient feedback and overall patient satisfaction with the NTC care experience.

2.3.2 Workforce

As previously reported[2], the Board exceeded the Scottish Government NRAC 2021 target for ANPs, and the workforce has continued to expand to enhance service delivery, particularly in areas where there is a reduced medical workforce. Table 1 outlines the ANP workforce data.

[2] EDG Report: Update on Transforming Roles: Advanced Nurse Practitioners, 20 April 2023

Table 1

Year	Acute		Partnership	
	B8	B7 (including Trainees)	B8	B7 (including Trainees)
2016	0	24.18	0	0
2021*	2	48.51	0	48.29
2022	3	49.08	2	31.45
2024**	5	44.54	4	32.73

*Inconsistencies in the recording of data may have resulted in incorrect results, therefore 100% data cleanse undertaken in 2022.
**eESS reported data (12 July 2024)

In 2023, the intent was to ensure that all ANPs met the 10% protected Non-Clinical Time (NCT) requirement in their job plans to enable delivery of the 3 remaining pillars of practice. Despite significant work, this is still not being achieved in most services and ANPs are reporting that this is having a negative impact on them personally, and their ability to meet the full ANP role specification.

2.3.3 Financial

Due to the current financial climate, the Senior Practitioner: Advanced Practice post vacancy in PPD has not been filled. Whilst the toolkit, forum and monthly CPD programme are now fully established, the lack of future support available to Services, ANPs and their managers may need to be considered in light of future NMC regulation.

2.3.4 Risk Assessment / Management

Previously, trainee ANPs have identified varying levels of clinical mentorship and supervision. Whilst there is now an ongoing CPD programme for all Advanced Practitioners to access, variation still exists in clinical supervision for ANPs. ANPs have identified there is a tendency for mentorship and supervision to cease once they are no longer trainees.

As identified in section 2.3.2, most ANPs state they receive no protected time for CPD or activities in the non-clinical pillars. The establishment of the Advanced Practice Council by the Executive Director of Nursing this year will enable the development of the AP Policy and Strategic Framework. Once implemented, the policy and framework, along with the implementation of the national Clinical Supervision Framework[3] will minimise the risk across the organisation by ensuring a standardised approach to job plans including NCT.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

[3] Clinical supervision national framework for nursing in NHS Scotland | Turas | Learn

2.3.6 Climate Emergency & Sustainability Impact

There are no anticipated impacts associated with the shared governance model and AP Policy and Framework.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

- Executive Directors' Group, 15 August 2024

2.4 Recommendation

This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices

None.

Report Contact
Mairi McKinley
Head of Practice and Professional Development
Email mairi.mckinley@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Allied Health Professions (AHP) Assurance Framework Update**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Amanda Wong, Director of AHPs**

Executive Summary:

- The AHP Professional Assurance and Governance Framework was presented to CGC last year.

- The AHP Professional Assurance and Governance review (supervision, appraisal, PDP and revalidation update) is being brought to the CGC for their awareness and assurance.

- All AHP registered staff have re-registered with the HCPC, after fulfilling their audit requirements in a timely manner; this means that all staff have provided the registration body with evidence that they are fit to practice and remain on the register.

- Supervision:
  - Supervision Contract Completed, 88%
  - Supervision Delivered, 91%

- PDP & Objectives:
  - Current Personal Development Plan, 81%
  - Objectives Agreed, 79%
  - Annual Appraisal, 81%

- The report provides the Committee with an assurance that all AHP’s in NHS Fife are up-to-date and are practising to the appropriate regulatory and professional standards.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Allied Health Professions Professional Leadership Council (AHPPLC) recognised the importance of having more robust processes around professional assurance and governance. To achieve this we developed the AHP Professional Assurance and Governance Framework; this was shared last year with CGC.

The AHP Professional Assurance and Governance review (supervision, appraisal, PDP and revalidation update) is being brought to the CGC for their awareness and assurance. The report provides the Committee with an assurance that all AHP's in NHS Fife are up-to-date and are practising to the appropriate regulatory and professional standards.

2.2 Background

Allied Health Professions is an umbrella term that covers 10 professions: Arts Therapists (Art, Music & Drama), Dietitians, Occupational Therapists, Orthotists, Orthoptists, Physiotherapists, Podiatrists, Prosthetists, Radiographers (Diagnostic and Therapeutic) and Speech & Language Therapists.

Any AHP wishing to practise their profession in the UK must be registered with the Health and Care Professions Council (HCPC). Professional assurance has always been provided around the re-registration process for the HCPC and this registration allows AHPs to practise and needs to be renewed every 2 years. This is to assure the public, patients, employers, and other healthcare professionals that registered AHP's are up-to-date and are practising to the appropriate regulatory and professional standards. However, it was recognised that we required more robust assurance that included a wider range of measures, including supervision, TURAS (Objectives and PDP) and this was all included within the framework.

2.3 Assessment

<u>HCPC Re-registration:</u>
Podiatry, 100%
Dietetics, 100%

Art Therapy, 100%
Physiotherapy, 100%
Radiography, 100%
Occupational Therapy, 100%
Prosthetists & Orthotists, 100%
Speech & Language Therapy, 100%

All AHP registered staff have re-registered with the HCPC, after fulfilling their audit requirements in a timely manner; this means that all staff have provided the registration body with evidence that they are fit to practice and remain on the register.

Supervision:
Supervision Contract Completed, 88%
Supervision Delivered, 91%

Our national supervision position statement sets clear expectations for the minimum levels of supervision and frequency etc and this was adopted in Fife.
We do expected staff to all have a supervision contract agreed and signed. This provides clear expectations of both the supervisor and supervisee, the frequency of supervision and documentation of discussion and agreed confidentiality etc. For 2023/24 we are sitting at 88%, for all staff, and given maternity leave and vacancy this figure provides a significant level of assurance that all professions are engaged in this.
Across all AHPs here in Fife 91% of staff are undertaking regular supervision sessions; again this provides a significant level of assurance that staff at all grades are engaged in this, and have access to a specified time and space to discuss their professional and workplace practice.

PDP & Objectives:
Current Personal Development Plan, 81%
Objectives Agreed, 79%
Annual Appraisal, 81%

Across all of the AHP professions, there is clear engagement in professional development planning, objective setting and appraisal. This provides professionals and the services they work within opportunities to improve and develop. It also ensures that staff are engaged in consolidating and developing both clinical and non-clinical knowledge, understanding, skills and expertise.

This report provides the following Level of Assurance: (add an 'x' to the appropriate box)

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Regular supervision, appraisal and PDP setting ensures that registered AHP's are up-to-date and are practising to the appropriate regulatory and professional standards. The re-registration process also provides an opportunity to provide further evidence, by using the formal appraisal and PDP structures and Continuing Professional Development Portfolio documentation to support the professional declaration.

2.3.2 Workforce

This continues to be challenging for all those working across the AHP professions and services. However, supervision, appraisal and PDP activities were continued throughout to ensure staff could provide adequate evidence to allow re-registration to take place. Having these processes and opportunities robustly provided, it has a beneficial impact with recruitment.

2.3.3 Financial

Nil

2.3.4 Risk Assessment / Management

Nil

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

Nil

2.3.6 Climate Emergency & Sustainability Impact

Nil

2.3.7 Communication, involvement, engagement and consultation

The AHPPLC has discussed this information in relation to specific Professional groups and AHP wide, and we have this as a standing agenda item. This has provided significant opportunities for learning and development between the professions, and we have our Practice Education Leads deliver supervision training in multi-professional groups. This report will be shared with the AHP Clinical Advisory Forum, as well as the AHP Learning & Development Group. These groups have a wide range of representation across the professions and from teams across the organisation.

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.

- AHP Professional Leadership Council, 6 August 2024
- EDG, 15 August 2024

2.4 Recommendation

This paper is provided to members for a **"significant"** level of assurance.

3 List of appendices

None.

Report Contact
Amanda Wong
Director of Allied Health Professions
Email amanda.wong@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Care Opinion Feedback Annual Report**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

Executive Summary:

- Care Opinion is an independent, not-for-profit social enterprise, where people can provide anonymous feedback to NHS Boards and services about their experience of care.
- Feedback is published on the Care Opinion website, where it can be viewed by the public, healthcare providers and regulatory bodies.
- The Patient Experience Team supports clinical teams and services to implement and manage Care Opinion at a local level.
- In 2023/24, NHS Fife received 1,223 stories on Care Opinion from patients, relatives, carers, friends, and staff posting on behalf of patients about acute and secondary services. This is an increase of 42.7% from the previous year.
- These stories have been read more than 121,449 times so far.
- NHS Fife has had a positive year (2023/24) achieving the 3rd highest number of shared stories among all the health boards in Scotland, consistently surpassing the average number of stories per head of population and maintaining above-average story positivity

1 Purpose

The purpose of this paper is to provide an annual report on Care Opinion activity.

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Local policy
- NHS Board Strategic Priority/ies – To Improve Quality of Health & Care Services

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

- Person Centred

2 Report summary

2.1 Situation

Care Opinion is an independent, not-for-profit social enterprise, where people can provide anonymous feedback to NHS Boards and services about their experience of care. It is intended to complement NHS Boards' processes for dealing with feedback and complaints.

Patients, service users and their families can share their experiences of health care services by posting stories on the Care Opinion website. All submissions are moderated to ensure they comply with the platform's guidelines, such as maintaining anonymity and avoiding defamatory content.

Once moderated the feedback is published on the Care Opinion website, where it can be viewed by the public, healthcare providers and regulatory bodies. Healthcare providers and organisations are encouraged to read and respond to the feedback. This interaction is also public, allowing for transparent communication between service users and providers.

Patient stories and feedback data is collected and analysed to identify trends, common issues, and areas for improvement. This information is used to improve services and inform policy decisions. By sharing their stories, users can directly influence the quality of care, highlight issues, and suggest improvements, fostering a culture of transparency and continuous improvement in health and social care services.

The Patient Experience Team supports clinical teams and services to implement and manage Care Opinion at a local level. They also manage the Care Opinion subscriptions for NHS Fife, working in collaboration and liaising with the Care Opinion Team, reporting, and sharing of data and stories and providing advice, support, and training to staff.

2.2 Background

Ongoing patient feedback ensures that care delivery is continuously evaluated and improved, aligning services with the principles of person-centred care. This approach focuses on providing care that is respectful of, and responsive to, individual patient preferences, needs, and values.

Care Opinion offers significant benefits for both patients and healthcare organisations. By providing a platform for patients to share their experiences, whether positive or negative, about the care they have received, empowering them to take an active role in their healthcare. This helps patients feel heard and valued, giving them a voice in their healthcare journey which is integral to the delivery and enhancement of healthcare services, fostering a collaborative and respectful relationship between patient and providers. It also allows other patients to better understand what to expect from healthcare services.

Publicly sharing feedback encourages accountability within the organisation, demonstrating a commitment to transparency and openness, enhancing the organisation's reputation, and building trust within the community. Patients can also find comfort and support by connecting with others who have had similar experiences. This sense of community can be particularly valuable for those dealing with chronic conditions or complex health issues.

Firsthand patient experiences can highlight strengths and weaknesses in care delivery, helping to identify areas for improvement, fostering a culture of excellence, and ensuring care delivery is continuously evaluated and improved. Positive feedback can boost staff morale and motivation, recognising their hard work and dedication. Conversely, constructive criticism can provide valuable insights for professional development and training needs.

2.3 Assessment

In 2023/24, NHS Fife received 1,223 stories on Care Opinion from patients, relatives, carers, friends, and staff posting on behalf of patients about acute and secondary services. This is an increase of 42.7% from the previous year, which had 857 stories in 2022/23.

82% of the stories were completely positive, while the remaining 18% had some level of critical feedback. Staff and services responded to these stories 1,756 times, with over 82% of the responses occurring within 7 days or less. These stories have been read more than 121,449 times so far.

NHS Fife’s community services fall under the HSCP, and story numbers are also increasing rapidly in this area, with an even higher positivity rating of 90% for stories.

The promotion of Care Opinion within the organisation continues with the Patient Experience Team regularly visiting clinical areas to offer support, training, and guidance, along with sharing good practices from other areas. Responders are being encouraged to add a photograph to their profile page. Adding a profile picture makes staff more visible, bringing comfort and ease to the person reading it and removing any confusion about who is responding. Helping those telling their story on Care Opinion feel like they are

conversing with a real person and that staff are reaching out to them from one human being to another.

In the summer of 2023, an additional member of staff joined the Patient Experience Team to help collect patient stories from patients who were unable to share their experiences. This led to an increase in the number of patient stories being shared. Unfortunately, this position was only active until December 2023. Late 2023 the Rapid Cancer and Diagnostic Service (RCDS) recruited its own dedicated volunteer to gather patient stories, which has resulted in an increase in valuable stories from this area. The Patient Experience Team is looking to recruit two to four volunteers to continue supporting this patient feedback service and will be able to support patient feedback across all services in NHS Fife.

These are the three most popular stories within Acute, out of all the stories between April 2023 and the end of March 2024.

Poor maternity care - 588 views

Posted by **Zoe29** as the patient 6 months ago

I received antenatal care at Ninewells Hospital from week 12 of my pregnancy to the early third trimester. My first scan was a generally unpleasant experience as the ultrasound technician just seemed to be having a bad day and blamed their inability to get some readings on me having a high BMI. I had two private scans prior to this with no issues and much clearer pictures with nicer technicians so I don't believe my weight actually impacted on...

When I was transferred to Fife - Kirkcaldy to be exact - my experience was night and day. Every doctor, midwife, nurse and ultrasound staff apologised for my experience in Ninewells and went what I thought was above and beyond for me, however when I listen to other people who received maternity care at Kirkcaldy I realise this is just their normal way of working. I was given the choice of what to do with my birth, I was told to eat and that I wouldn't be harassed every week and my weight was a complete non-issue to everyone

With the support of medical staff I found a strength within me. - 555 views

Posted by **staffmemberfife1** as a staff member posting for a patient/service user 8 months ago

I had gone to see my GP and was referred immediately to Admissions Unit 1 in the Victoria Hospital then I was transferred to Ward 32 (Medicine of the Elderly)

I have been in hospital many times so I am familiar with Hospital routines.

On my last admission to the Victoria Hospital I saw Dr Finch in Respiratory Medicine He was just brilliant. I am most grateful for his care and early diagnosis of Lung Cancer. He really is just brilliant...

Dads stay ward 2 glenrothes hospital - 462 views

Posted by **squeezy1** as a relative 11 months ago

My dad was admitted into ward 2 glenrothes hospital in January this year having spent the previous 5 months in Victoria Hospital. My dad has several co-morbidities on top of this was diagnosed with hypo delirium and was recovering from a hip fracture he was refusing to eat and take his meds.

The difference in my dad since moving to ward 2 at glenrothes has been incredible. He no longer displays symptoms of delirium, he is able to walk with a...

These are the three most popular stories within Community Services, out of all the stories between April 2023 and the end of March 2024.

Unhappy with mental health support. - 284 views

Posted by **omegagc68** as a service user 4 months ago

I have had a diagnosis of Autism Spectrum Disorder since childhood, and a diagnoses of Borderline Personality Disorder (BPD) after a brief stay in a psychiatric inpatient unit.

While I absolutely agree that I am Autistic, I believe the Borderline Personality Disorder label is wrong. I feel I was labelled without having a proper screening from any professional.

Since having been labelled with this diagnosis, I have felt absolutely...

The RCDS team were great - 237 views

Posted by **rcdsal19** as a service user 2 months ago

I was referred to the hospital for various tests following a visit to my doctor as I was losing weight and feeling a bit low. I was given appointments to attend Victoria Hospital for an ultrasound and Queen Margaret for a CT Scan and Endoscopy.

I was very anxious about attending the hospital as it can be a daunting experience particularly if you are older and unsure of where to go when you arrive. It can be distressing if you are not a...

Aftercare following a Heart Attack - 223 views

Posted by **Honest Itwisnae Sair** as the patient 11 months ago

I do agree with the various negative comments levelled at NHS Scotland.

However in my case I nothing but praise for all areas of the NHS for the treatment during and after my recent Heart Attack. Myself and family are so grateful to the NHS staff particularly the community cardiac service

NHS Fife has had a positive year (2023/24) achieving the 3rd highest number of shared stories among all the health boards in Scotland, consistently surpassing the average number of stories per head of population and maintaining above-average story positivity. This success is attributed to the dedication and hard work of the staff across NHS Fife, who actively seek feedback on Care Opinion, take time to respond to stories, and learn from the shared experiences of authors.

This report provides the following Level of Assurance: (add an 'x' to the appropriate box)

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work. The Organisational Learning Group will review themes, trends and lessons learned from Care Opinion, complaints and adverse events, which can be triangulated with activity and staffing resources.

By analysing data from patient experience feedback offers significant insights into improving the quality of care and services. This process, when combined with regularly reviewing themes, trends, and lessons learned, can identify critical areas for improvement and help develop strategies to enhance patient experience, safety, and outcomes.

Ensuring healthcare delivery is aligned with patient needs and values**,** achieving the best possible health outcomes that matter to patients rather than merely providing services, ultimately leads to better health outcomes and value-based care. Measuring success based on patient satisfaction and experience can ensure that the care provided aligns with patient expectations and improves their quality of life.

2.3.2 Workforce

The Patient Experience Team establishment that manages Care Opinion consists of 1.0 WTE Band 8b, Head of Patient Experience and 1 WTE Band 4 Senior Administrator.

There is one Volunteer working with the RCDS to gather patient stories and discussions have taken place with the Volunteering Lead, to recruit Volunteers to support in gathering patient feedback in the form of Care Opinion and Lived Experiences. There are two candidates interested who are going through the recruitment process with a further two candidates who have shown an interest in supporting.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Patient feedback and learning from what has gone well and what could have gone better is vitally important in reducing reputational risk as it enables the organisation to address issues proactively, improve services, communicate transparently, build trust, comply with regulations, and foster a culture of continuous improvement. Actively contributing to a positive reputation and a stronger more resilient organisation.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.

- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact
n/a

2.3.7 Communication, involvement, engagement and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting
Executive Directors' Group, 15 August 2024.

2.4 Recommendation
This paper is provided to members for a **"moderate"** level of assurance.

3 List of appendices
None.

Report Contact
Siobhan McIlroy
Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Controlled Drugs Accountable Officer Annual Report**
Responsible Executive:	**Fiona Forrest, Acting Director of Pharmacy and Medicines / Controlled Drugs Accountable Officer**
Report Author:	**Victoria Robb, Lead Pharmacist Medicines Safety** **Ashley Balloch , Specialist Pharmacy Technician**

Executive Summary

- The purpose of this report is to provide assurance that the roles and responsibilities of the Controlled Drugs Accountable Officer (CDAO), were fulfilled in the management of controlled drugs (CD's) across Fife, during the period April 2023 to March 2024.
- The report outlines the actions undertaken during 2023/24 to provide a **significant level of assurance** with regard to fulfilment of the responsibilities of the CDAO.
- The report also outlines the CDAO workplan for 2024/25.

1. Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The purpose of this report is to provide assurance that the roles and responsibilities of the Controlled Drugs Accountable Officer (CDAO), were fulfilled in the management of controlled drugs (CD's) across Fife, during the period April 2023 to March 2024.

2.2 Background

The roles and responsibilities of Controlled Drugs Accountable Officer (CDAO), and the requirement to appoint them, are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013. The CDAO is responsible for the management and safe use of CDs, for monitoring systems, and taking action where appropriate, and to ensure co-operation between responsible bodies. There is a legal duty to share information between bodies such as health boards, private hospitals and hospices, the Care Inspectorate, NHS Scotland Counter Fraud Services and the police. It is a requirement for all NHS Board CDAOs to establish a Local Intelligence Network (LIN) to support information sharing. There is a multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes.

2.3 Assessment

Please see attached Controlled Drugs Accountable Officer Annual Report (Appendix 1).

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

The safe and effective management of controlled drugs and learning and taking actions from incidents, leads to improved patient care.

2.3.2 Workforce

To support the workforce with compliance against policies and procedures, a range of resources, training sessions and guidance documents are provided to all staff in NHS Fife and where appropriate, care homes and community pharmacies.

2.3.3 Financial

There are no direct budgetary concerns.

2.3.4 Risk Assessment / Management

NHS Fife has an adverse event policy (GP19) that outlines how to report an adverse event and the process that follows in terms of reviewing and grading the event to ensure lessons are learned and improvements are made for the future. Specific events must also

be reported to external agencies. Major CD incidents are managed via the Serious Adverse Events Process, with oversight of the Medicines Safety and Policy Group (MSPG) and monitoring by the CD Governance Group (CDGG).

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

No requirement for Equality and Diversity assessment at this time.

2.3.6 Climate Emergency & Sustainability Impact

None

2.3.7 Communication, involvement, engagement and consultation

The attached report details communication, engagement and consultation with multiple agencies both internally and external to NHS Fife.

2.3.8 Route to the Meeting

This report has been discussed by the following groups:

- Pharmacy Senior Leadership Team- 14th August 2024
- Controlled Drugs Accountable Officer Group- 14th August 2024
- Clinical Governance Oversight Group - 20th August 2024
- Area Drug and Therapeutics Committee- 21st August 2024
- Executive Directors- 26th August 2024

2.4 Recommendation

This paper is provided to members for a **"significant"** level of assurance with regard to fulfilment of the responsibilities of the Controlled Drug Accountable Officer.

The Committee is asked to **discuss** the report and 12 month workplan.

3 List of appendices

- Appendix 1 - Controlled Drug Accountable Officer Annual Report

Report Contact
Victoria Robb
Lead Pharmacist Medicines Safety
Email victoria.robb2@nhs.scot

Controlled Drugs Accountable Officer Annual Report 2023/24

August 2024

Contents

1. Purpose of Report....3
2. Governance 3
3. Controlled Drug Assurance Assessments 4
a. CD Cupboard 5
b. Key Security....6
c. CD Record Book 7
d. Patient's Own CDs....7
e. Requisition entries **8**
f. Stock Check....**8**
g. Liquid CD Check....**8**
4. Destruction of Controlled Drugs 9
5. Prescribing 9
6. Reporting and Learning 10
a. Incidents - Acute Serviices and HSCP....12
b. Community Pharmacy Incidents 14
7. Controlled Drug Local Intelligence Network 166
8. Controlled Drugs Accountable Officer Workplan 17

1. Purpose of Report

As a Health Board, NHS Fife is required to appoint a Controlled Drugs Accountable Officer (CDAO). The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The CDAO is responsible for the following in relation to Controlled Drugs:

- governance
- obtaining and receiving
- storage and access
- prescribing
- dispensing and supply
- destruction
- transport
- stationery
- reporting and learning
- the operation of Local Intelligence Network.

The purpose of this report is to update the Committee on the work ongoing to ensure the safe and effective use of controlled drugs (CDs) within Fife. The detail captured in the report demonstrates the multiagency approach within Fife around CDs with input from Police Scotland P division, the NHS, Fife Council, the Local Medical Committee, the General Pharmaceutical Council and Care Homes.

The report covers the period from **1st April 2023 to 31st March 2024.**

2. Governance

In NHS Fife, the Director of Pharmacy and Medicines also fulfils the role of CDAO.
For the period of this report, Benjamin Hannan was registered with Healthcare Improvement Scotland (HIS), as NHS Fife's CDAO,. The Controlled Drugs (Supervision and Management and Use) Regulations 2013 mandate that "*HIS must*

compile, maintain and publish from time to time, in such manner as it sees fit, a list of accountable officers of designated bodies in Scotland."

Standard Operating Procedures (SOPs) and policies are in place covering all aspects of CD management in NHS Fife and these are regularly reviewed and form part of the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP). A programme of assurance is overseen by the Controlled Drug Governance Group (CDGG), which reports to the Medicines Safety and Policy Group. This group has responsibility to ensure that safe and secure systems are in place and monitored for ordering, supply, administration, storage and prescribing of CDs. The Medicines Safety and Policy Group (MSPG), reports to the Area Drug and Therapeutics Committee (ADTC) and Clinical Governance Oversight Group.

3. Controlled Drug Assurance Assessments

A programme of CD Assurance Assessments ensures that every ward/department holding CDs in NHS Fife receives a six monthly pharmacy visit, to assess compliance with legal and best practice requirements. It should be noted that processes for seeking assurance regarding other requirements (destruction, prescribing, reporting and learning, and the operation of the CD Local Intelligence Network) are covered separately in this report.

A comprehensive 60-point assessment against "gold standard" practice, is undertaken jointly by a member of the nursing team with a pharmacy professional. Standardised methodology for completion of this assessment is in place. The assessment splits 60 questions into 7 domains, which are broadly aligned to the CDAO responsibilities - storage and access, obtaining and receiving, dispensing and supply, transport and stationery. The outcome of the assessment informs compliance against these requirements for CDs.

Following the assurance assessment, an individualised action plan for each area/ward/department is recorded and implemented, by the Senior Charge Nurse (SCN) or equivalent, with oversight of Heads of Nursing, via local governance processes within Acute Services and HSCP.

Due to the comprehensive nature of the assessment, covering a detailed review over a 6 month period, it is important to understand that it is not expected to achieve 100% compliance in this context. This process is intended as an assurance assessment rather than a formal audit. The primary goal is to evaluate the overall effectiveness and reliability of the processes in place, rather than to identify every single instance of non-compliance.

Only four of the 100 clinical areas were noted to be 100% compliant with all aspects of the assessment; the detail below and variation across all settings is due to the scrutiny applied in reviewing each area individually. An organisation action plan for controlled drugs will be developed, to support staff to ensure learning is embedded into practice and will be reviewed by the Medicines Safety and Policy Group (MSPG). Each ward/ department will undertake self-assessment reviews in between the main audit cycles. Full details of the assessment have been made available to Head of Nursing for their areas, to ensure that all local actions have been completed.

A breakdown of assessment outcomes for each domain can be found below in Table 1:

Table 1 Results of Compliance with Assurance Assessment, by Domain

Domain	Compliance 2023 (100 areas)
CD Cupboard	92%
Key Security	83%
CD record book	82%
Patients' own CDs	85%
Requisitions	90%
Physical stock	99%
Liquid CD check	63%

a. CD Cupboard

Areas of good practice

- All CD cupboards were found to be locked and in good working order.
- Two assessments noted that non-controlled drugs were being stored in CD cupboards and this was rectified at the time of the audit. One where there was a controlled drug found outside the CD cabinet which was rectified at the time of audit.
- All requisition books were held in the CD cupboard, 3 areas held more than one CD requisition books, which was rectified at time of the audit.

Areas for Improvement

- 20 areas had no stock list on the ward compared to 21 the previous year
- 40 were advised to update and/or review their stock lists compared to 33 in the previous year

Proposed actions – develop a Standard Operating Procedure (SOP) and Key Performance Indicator for stock list reviews and deliver learn at lunch sessions to support these.

b. Key Security

Areas of good practice

- Keys were found to be securely stored away from other ward keys in all but three areas.
- All areas were noted to retain spare keys in a secure place, with limited access, including wards not open 24/7.

Areas for Improvement

- 25 of the 100 areas (25%) had missed at least one of the twice daily mandated stock checks and 21 areas had not recorded key handover appropriately. The need to complete this record at each shift change was highlighted at time of the assessment.
- 16 areas did not have spare keys or did not know where they were. Advice was given to 12 areas to ensure they were recording weekly checks regarding the security of duplicate/spare keys for cupboards.
- Four areas retained the CD key within a key safe in the area when not manned 24/7. New guidance was launched in v10 of the SSUMPP, where spare keys will be held in a central location on each hospital site and monitored weekly.
- A rolling programme has started with Health and Social Care Partnership (HSCP) wards being the first areas to move to the new model with the aim of all ward/departments to have the new model in place by October 24.

Proposed action –The CD Governance Group will oversee the development of Standard Operating Procedures for management of spare keys aligned to the SSUMPP, with implementation across all sites.

c. **CD Record Book**

Areas of good practice

- All areas were found to store CD record book securely.

Areas for Improvement

- Six books were not in a good condition and areas were recommended to replace these books.
- 20 areas were given advice on how to appropriately record balance transfers between books, which has deteriorated from last year (where only nine areas were non compliant). Administrative errors were noted across a number of different recording requirements; however no significant concern from any individual error were identified.
- Nine areas completed destructions of controlled drugs whre were not witnessed by appropriate staff. Two areas had more than three spillages/breakages over the six month period but no further concern was raised.
- Three areas completed ward to ward transferrs out with SSUMPP guidance.
- 35 areas were running low of CDs or had too many CDs; review of CD stock lists will support staff with compliance going forward.

Proposed actions – introduce a new CD register to improve accurate and complete data entry. Promote good practice for recording of entries and destruction of CDs, through training and education, including a Medicines Safety Minute.

d. **Patients' Own CDs**

Areas of good practice

- All but one area that use Patients' Own CDs were using the patients' own CD book.
- All Patients' Own CDs were stored correctly and records were clear.

- Two Patients' Own registers were recommended to be replaced at the time of the assessment. Administrative errors were noted in the use of these books.

Areas for Improvement

- Improvement action was noted in 21 areas regarding transferring of Patients' Own CDs.

Proposed action – promote good practice through training and education, including a Medicines Safety Minute focusing on Patients' Own Controlled Drugs

e. Requisition entries

Areas of good practice

- All stock and transactions were accounted for at the time of the audit.

Areas for Improvement

- Across the sample there were a small number of administrative errors noted (e.g. missing signatures); advice was given to each area to rectify.
- "Received by" in the requisition book is the largest non-compliant area with 45, followed by 15 "requisition number" not in CD register.

Proposed action – promote good practice through training and education including a Medicines Safety Minute focusing on recording of Controlled Drugs.

f. Stock Check

Areas of good practice

- Compliance with the stock check was achieved in 98% of areas

Areas for Improvement

- Non-compliance was identified in two areas.
- One area had a liquid medication that had not had the date opened recorded, on further investigation it was identified that this product had expired.

- In another area, a discrepancy was identified during the stock count, the number of patches in the register did not match the physical count; a DATIX was created for further investigation.

Proposed action – promote good practice through training and education including a Medicines Safety Minute focusing on completion of stock checks.

g. Liquid CD Check

Area for Improvement

- 19 areas that held liquids did not rebalance the stock in line with SSUMPP when a new bottle was opened.

Proposed action – promote good practice through training and education including production of a video to support staff with compliance.

4. Destruction of Controlled Drugs

Destruction of controlled drugs is covered by the CDAO regulations. Appropriate Standard Operating Procedures (SOPs) are in place for the destruction of CDs and SSUMPP covers the process for the removal and destruction of illicit substances from patients. The process ensures that unwanted CDs awaiting destruction are recorded, not stored for an excessive length of time, and do not accumulate. Appropriate records are made when CDs are destroyed, and processes are in place for witnessing the destruction and disposal of stock CDs. For non-NHS wards and departments, the CDAO authorises individuals who can witness the destruction of stock CDs. In the reporting period, 87 authorised witness visits were undertaken by the pharmacy team. A key performance indicator is in place to ensure that 80% of Authorised Witness destructions were completed within 12 weeks of request. During this reporting period this target was met with 90% completed within 12 weeks. Ward and department destructions are not currently monitored by the local pharmacy team. This process is changing to standardise this process and to capture data.

5. Monitoring

Since April 2023, a dashboard was developed to enable monitoring of ordering of CDs and those deemed “attractive” and at risk of diversion, across all wards and clinical areas. The dashboard is reviewed by senior nursing, medical and pharmacy teams, within each ward/ clinical area every month, as an early warning system, to identify trends, themes and any issues in relation to ordering of these medicines. The Pharmacy and Medicines Directorate has set a Key Performance Indicator of 100% for these monthly reviews, which has been achieved consistently since January 2024.

6. Prescribing

Fife was a recognised outlier from National Therapeutic Indicators (NTIs) in opioids and gabapentinoids and had a higher than Scottish average involvement of such medicines implicated in drug related deaths. This led to the establishment of the High-Risk Pain Medicines (HRPM) programme which aimed to develop a whole system approach to alternative ways of managing pain, provide assurance on the safe and effective prescribing of these medicines and to create a culture change in prescribing to optimise patient benefit and minimise risk of harm to patients.

One of the key actions from the programme which was undertaken during 2023/24, was the production of quarterly prescribing reports for GP Practices, to review and identify actions to reduce prescribing of these medicines. The impact of these actions will be assessed through quarterly monitoring of National Therapeutic Indicators and local prescribing indicators. Analysis of the latest available data released in July 2024 (March 2024 data) shows that whilst Fife remains above the Scottish average in 4/8 areas, there is a more favourable trend than Scotland in 7/8 areas. Notably Fife has shown a greater % reduction than Scotland in measures for 3 HRPM groups (Opioids, Benzodiazepines, and NSAIDs). Both Fife and Scotland have shown a slight increase in Gabapentinoid measure however Fife has seen a lower % increase compared to Scotland (+2% cf +6%).

‘*More’* reports are generated where individual patients are prescribed above the Scottish average quantity. Individual prescribers are asked to review the patient, the clinical indication and to review quantity prescribed. Any concerns by the CDAOs team are noted and actioned accordingly.

Prescribing reports for prescriptions produced by private prescribers of controlled drugs via a PPCD are not currently available. This is a national issue which has been escalated to the CDAO Executive Group to be managed nationally through a Memorandum of Understanding with National Services Scotland.

7. Reporting and Learning

Fife demonstrates an open culture that encourages reporting of CD related incidents. This is demonstrated by a good reporting rate of incidents, with a low proportion of harm. The Managed Service report CD incidents via DATIX and independent contractors report CD incidents via the CDAO Incident Reporting form. In 2023-24, Community Pharmacists were the only independent contractors who reported incidents. Reporting by other independent contractors will be scoped through self- assessment audits.

392 CD incidents were reported via DATIX in 2023-24, compared to 390 reported in 2022-23. Incidents involving CDs are dealt with as part of the Adverse Events Process. “Major” CD incidents are reviewed by the CDAO, Medical Director and Director of Nursing, aligned with the Significant Adverse Event review process.

All incidents related to CDs have oversight of the multi-professional CD Governance group and the CDAO group, which includes senior pharmacy staff.

Since January 2023, all medication incidents (including controlled drugs) are reviewed each week by a multi-professional medicines safety group, to identify key themes and learning, which results in a weekly safety briefing being issued for quick dissemination of lessons learned from the previous week’s medication incidents across Fife.

Incidents for this period have undergone local investigation and resolution with oversight of the Lead Pharmacist for CDs and Specialist Pharmacy Technician for CDs. Information is shared, particularly where there is “suspicion of criminality”, with responsible bodies including the police, Counter Fraud, private establishments, other Health Board CDAOs, the Care Inspectorate and regulatory bodies. Where required, incidents may be subject to further police or Counter Fraud Services investigation.

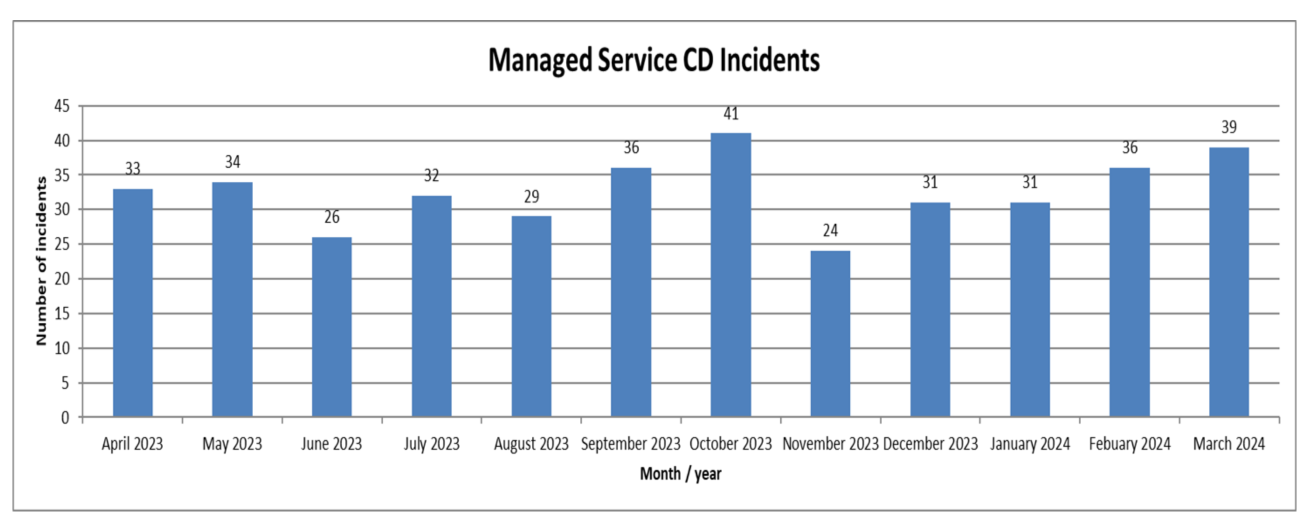
a. **CD Incidents across Acute Services and HSCP**

Graph 1 shows CD incidents reported via Datix by month during the time period April 2023- March 2024. Of the 392 incidents reported:

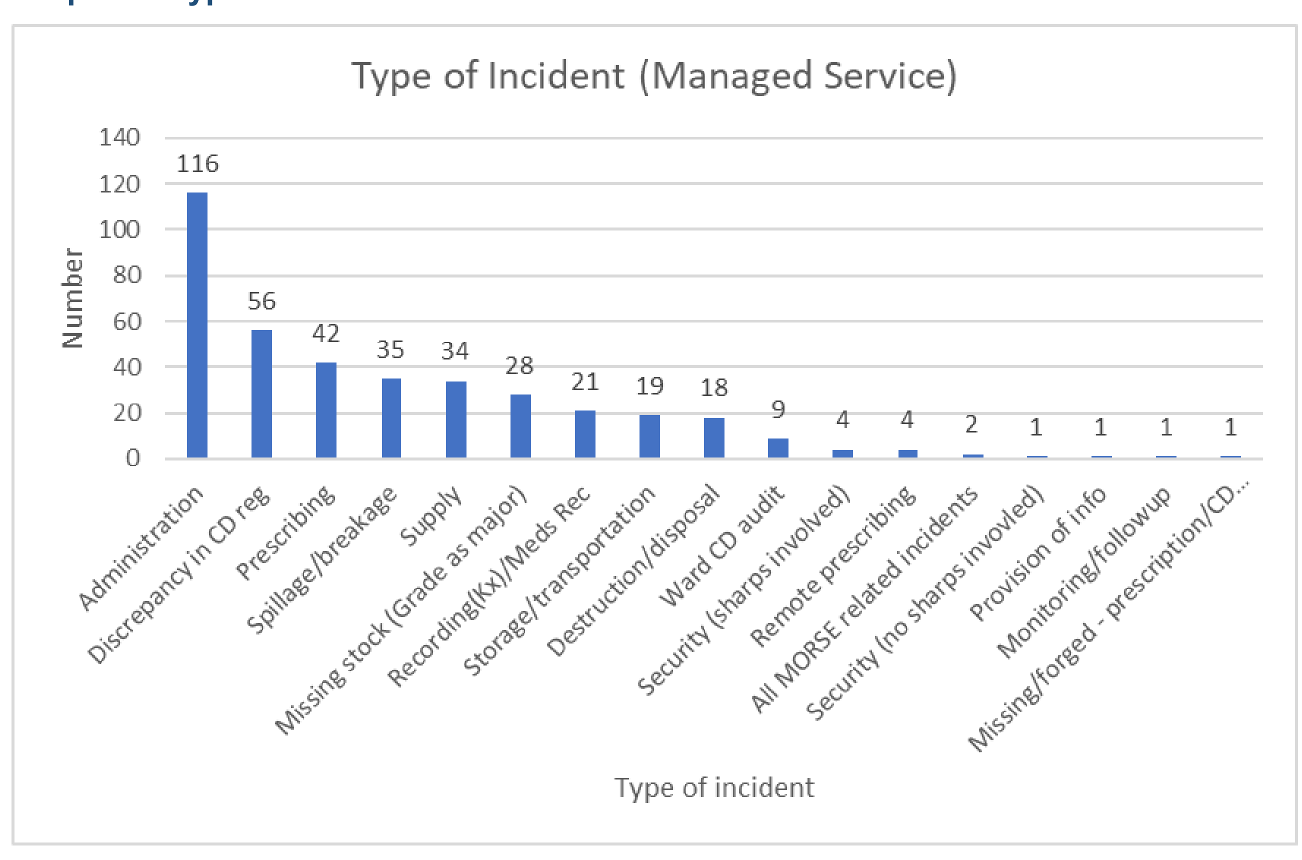
- 294 (75%) were recorded as **no outcome** in terms of harm
- 46 (11.5%) were recorded as **minor** outcome in terms of harm
- 42(11%) were recorded as **moderate** outcome in terms of harm
    - 11 CD discrepancies
    - 1 prescribing error
    - 9 Administration errors - 1 patient received the wrong medicine, 4 patients did not receive their medication, 1 patient was given the wrong quantity, 2 patients received the wrong dose and 1 patient was given the wrong form of medication.
    - 10 missing stock, these incidents are investigated following procedures and where appropriate downgraded or escalated.
    - 2 recording errors
    - 5 Supply errors
    - 1 was identified as part of a ward CD audit
    - 2 Storage and transport
    - 1 destruction/disposal
- 10 (2.5%) incidents were recorded as **major** outcome in terms of harm
    - 8 of these incidents were due to "missing stock" which cannot be accounted for. These incidents are investigated following procedures, and a SAER undertaken.
    - 2 Incidents related to suspected theft involving staff members

During this period, administration incidents (116) continue to be the most common type of CD incident reported. Incidents involving a discrepancy (56) remained the second most common type. Prescribing incidents (42) replaced supply incidents during this period as third highest type of incident.

Graph 1 – Number of CD Incidents - Acute Services and HSCP



Graph 2 – Type of CD Incident - Acute Services and HSCP



NOTE – there are 28 “missing stock (grade as major)” in the above graph but only 10 described in the narrative as 18 were downgraded following investigation.

Graph 3 highlights the top 5 CDs involved in CD incidents. Oxycodone continues to be the most reported drug followed by morphine. Medicine safety huddle education and awareness sessions continue with a focus on common errors and the safer administration of medicines, specifically highlighting the difference between Oxycodone and morphine. Lanyards and stickers are also being developed to support staff with oxycodone / morphine selection. Buprenorphine is no longer in the top 5 replaced by Diazepam.

Graph 3– Top 5 Drugs Reported in CD incidents- Acute Services and HSCP

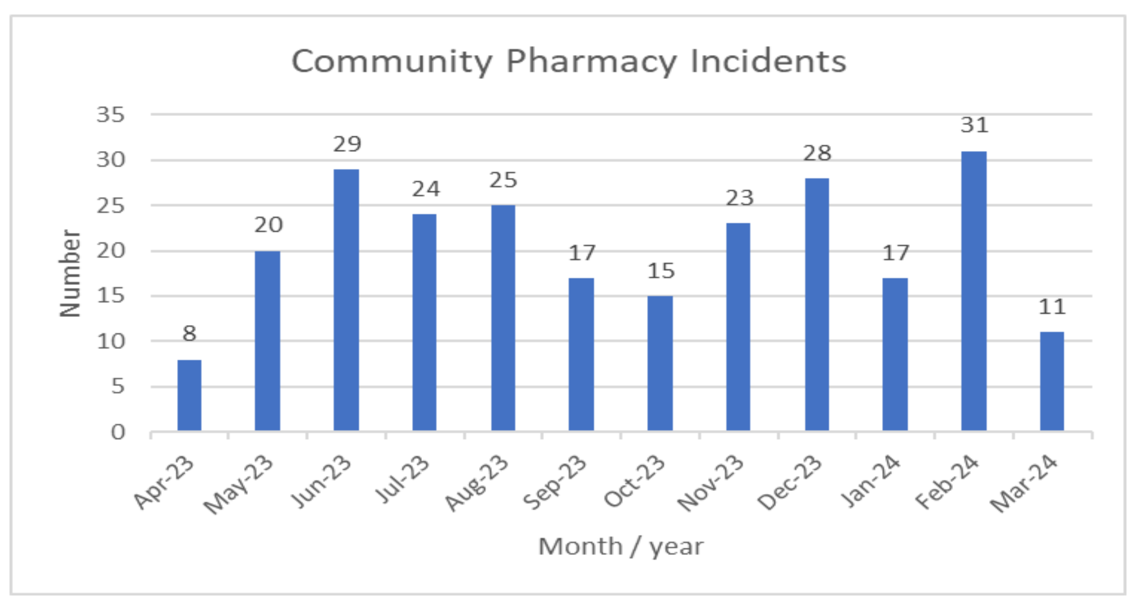
Oxycodone 142
Morphine 81
Fentanyl 28
Methadone 23
Diazepam 14

b. Community Pharmacy Incidents

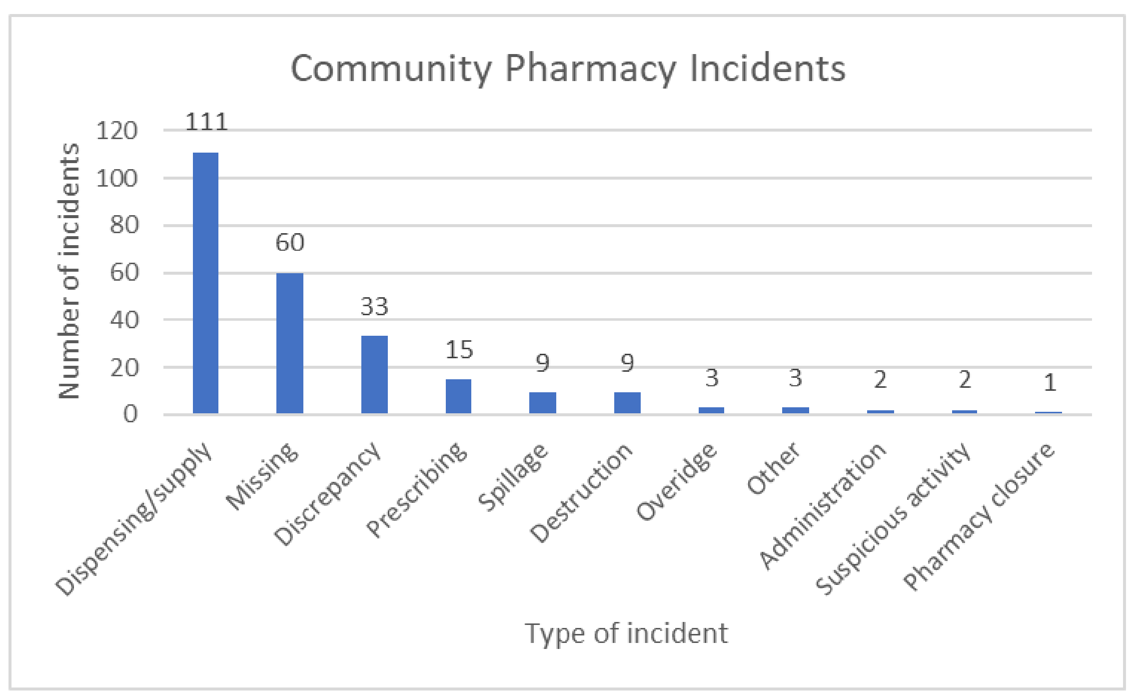
Community Pharmacies in Fife are required to report CD related incidents to the CDAO. **248** CD incidents were reported by community pharmacies, via the CDAO Incident Reporting form which is a significant increase from the 143 reported 2022-23. This increase may be due to increased awareness of reporting process and also due to the change in ownership of a group of pharmacies, resulting in a number of incidents being reported.

Graph 4 shows the breakdown of incidents reported by Community Pharmacy during 2023/24 and Graph 5 shows the breakdown of type of incidents.

Graph 4 Number of Community Pharmacy Incidents by Month



Graph 5 Community Pharmacy Incidents by Type



Of the 248 incidents reported 108 incidents were related dispensing/ supply incidents.

The next most common type of incidents was missing CDs or unexplained loss at 57 followed by CD register discrepancy at 37.

2 suspicions of criminality were notified and both incidents were reported to the police.

Oxycodone (55) has replaced Methadone as the most common medicine reported in incidents from community pharmacy followed by Morphine (45) and Methadone (38).

8. Controlled Drug Local Intelligence Network

The East Region Controlled Drug Intelligence Network (CD LIN) meets twice a year, with chairing of the group rotated across Lothian, Borders and Fife.

In May NHS Fife presented High Risk Pain Medicines Programme to raise awareness of all the work ongoing within the region around the prescribing of controlled drugs. In November, NHS Fife presented NHS Fife Provision of Medicines Discharge Audit

Guidance for dealing with CFS (Counter Fraud Services) Alerts was discussed and has been sent to the CDAO Executive Group for national approval, in order to standardise the process across all boards.

NHS Boards continue to share alerts where there have been fraudulent attempts to obtain medication from community pharmacy and GP practices. These alerts are then shared with NHS Fife community pharmacies and GP practices to raise awareness.

Counter Fraud Services also send alerts mainly from crime stoppers where allegations have been made regarding in the main patients or staff supplying medication. All are investigated at the time and the results of the investigation reported back to CFS and the police notified where appropriate.

The General Pharmaceutical Council, who regulate community pharmacy, carry out inspections of community pharmacies on a rolling programme. Inspection reports are available to the public to view on GPhC website. GPhC require improvement action plans to be filled in by the owner and superintendent pharmacist and completed in a specified time scale no longer than 60 days. The pharmacy is then revisited again in 6 months time.

NHS Fife participates in the CD Accountable Officers Network (CDAON), which meets quarterly to develop detailed policies and documentation, and to develop and implement

CD regulations and legislation. Peer review sessions are included in the programme. NHS Fife supports the network by reviewing documentation, sharing NHS Fife policy and procedures and support peers with advice and guidance.

The Care Inspectorate has powers to seek self-declarations about how care homes manage and use CDs. The CDAON reviews the information collected annually to inform improvement work and to promote information sharing. The Care Inspectorate also shares information in real time where there is a particular concern, while NHS Fife support with investigation and recommendations and share any learning. The Care Inspectorate continues to work closely with the CDAON to support effective communication and national monitoring of CDs, and improved practice in the care sector.

9. Controlled Drugs Accountable Officer Workplan 2023/24

Update on CDAO Workplan for 2023/24:

Action	Complete by
Implement peer review processes across Acute Service Division wards and departments to support continued assurance.	Complete
Review the inspection model for GP practices and start inspection process.	Carry Forward to 2024/25 workplan – this model is now being reviewed by the CDAOWG at a national level
Issue self-assessment questionnaires to all Dental Practices in Fife.	Revised deadline October 2024
Launch a new ward CD register, developed nationally, which has an improved index and recording of part used CDs.	Not completed- using old stock before ordering new registers. Revised deadline December 2024
Review NHS Lothian workbook for controlled drugs and how that can be incorporated within national competency assessment	Carry Forward to 2024/25 workplan – deadline revised to Dec 2024
A Sway newsletter to be developed incorporating learning from CD incidents.	Complete
Develop additional tools to support staff to highlighting differences between oxycodone and morphine such as	Complete

Lanyard ,poster and stickers.	
Develop new CD audit tool in electronic format and start next cycle of CD ward audits.	Complete
Develop a new medicines safety workshop series building on the launch of the Medicines Safety Minute, with oxycodone/morphine video being episode one	Complete
Improvement plan from CQC self assessment to be developed	Complete
Develop a new electronic form for reporting CD incidents from community pharmacy	Complete
Develop new procedure for review of the attractive stock dashboard on a monthly basis	Complete
Completed detailed analysis of supply incidents involving CDs via Datix	Complete

10. **Controlled Drugs Accountable Officer Work plan 2024/25**

A workplan for continued improvement of of CD governance has been developed. Priorities for the coming 12 months are:

Action	Complete by
Develop tools to minimise incidents related to liquid discrepancies	September 2024
Review CDAO monthly report format	September 2024
Develop a 2024/25 medicines safety education and training workshop series and resources, linked to actions identified in the controlled drug assurance assessments.	October 2024
Complete inspection of QMH and VHK Pharmacy Department	November 2024
Review the inspection model for GP practices and start inspection process.	December 2024
Issue self-assessment questionnaires to all Dental Practices in Fife.	December 2024
Review CD assurance process	December 2024
Review new dashboard and update reporting formats for	December 2024

CDGG	
Review NHS Lothian workbook for controlled drugs and how that can be incorporated within national competency assessment	December 2024
Launch a new ward CD register, developed nationally, which has an improved index and recording of part used CDs. Noting – Current stock to be used first	March 2025

Report Contact
Author - Victoria Robb
Author’s Job Title – Lead Pharmacist Medicines Safety
Email victoria.robb2@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**6 September 2024**
Title:	**Review of Deaths of Children & Young People Annual Report 2023/24**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Lesley Cunningham, Coordinator – Child Death Oversight Panel**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Annually there is a requirement for Health Boards to publish a Children and Young Person's Death Review Report.

2.2 Background

The Child Death Oversight Panel in Fife was commissioned in response to the introduction of the mandatory process for developing a formal child death review process in Scotland.

National guidance was produced at the request of the Scottish Government by the Care Inspectorate and Healthcare Improvement Scotland who together formed the National Hub for Reviewing and Learning from the Deaths of Children and Young People.

Scotland reportedly has one of the highest rates of death in children and young people in Western Europe. It has been estimated that around one quarter of the

deaths could be avoidable, therefore it is imperative that we maximise available and meaningful learning from all deaths regardless of cause. https://www.gov.scot/publications/child-death-review-report-scottish-government-child-death-review-working-group/

2.3 Assessment

The report outlines the work of CDOP over the fiscal year, detailing the process for managing reviews of child deaths and the governance and reporting structures. Along with the overview of the work of the group, the report presents the data collected from the 20 deaths that occurred in the reported period 1st January 2023 to 31st March 2024 on every Fife child who died (the deaths may have occurred in a different location, but their permanent address is within Fife). The report considers information from the 20 deaths reported in the 15 months however a more detailed analysis of fully completed reviews will be available in next year's report due to delays in completing review that is multifactored. Learning from reviews section focuses on completed death reviews from 2022.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

A robust review process for every child death is required to maximise available and meaningful learning from all deaths regardless of cause, to contribute to improving the health and wellbeing of Fife children.

2.3.2 Workforce

The substantive staffing of the Child Death Review Team consists of dedicated Lead Paediatric Consultant, Band 7 Child Death Review Coordinator with Administration support from the Clinical Governance Team.

2.3.3 Financial

The costs associated with the workforce were met by NHS Fife.

2.3.4 Risk Assessment / Management

N/A

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

For the report, the term child will describe those under the age of 18 in line with the UN Convention of the Rights of the Child (UNCRC).
An Equality Impact Assessment (EQIA) stage 1 was completed for the child death review process and has been published on the NHS Fife website. Equality Impact Assessment (EQIA) | NHS Fife

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This report has been shared and agreed by Mrs Janette Keenan, Director of Nursing.

- NHS Fife Clinical Governance Oversight Group 20th August 2024
- Child Death Oversight Panel 15th March 2024
- Child Death Governance Group 12th December 2023

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.

- Child Death Oversight Panel 15th March 2024
- Child Death Governance Group 12th December 2023

2.4 Recommendation

This paper is provided to members for a **"significant"** level of assurance.

3 List of appendices

- Appendix 1 - Learning from the Deaths of Fife's Children and Young People Annual Report 2023 - 2024

Report Contact
Lesley Cunningham
Child Death Oversight Panel Coordinator
Email: lesley.cunningham2@nhs.scot

CHILD DEATH OVERSIGHT PANEL (CDOP)

Annual Report 2023-2024

TABLE OF CONTENTS

1. Introduction 2
2. CDOP Purpose.. 3
3. CDOP Membership and Structure 4
4. CDOP Process 5
5. Data Analysis 6
6. Learning from Reviews..................... 10
7. Training 12
8. CDOP Achievements 2023-2024...... 13
9. CDOP Priorities 2024-2025 14

1.INTRODUCTION

1.1 The death of a child is a devastating loss that profoundly affects all those involved. Sadly Scotland has one of the highest rates of death in children and young people in Western Europe. It has been estimated that around one quarter of the deaths could be avoidable, therefore it is imperative that we maximise available and meaningful learning from all deaths regardless of cause[1].

National guidance was produced in 2020 at the request of the Scottish Government by the Care Inspectorate and Healthcare Improvement Scotland (HIS) who together formed the National Hub for Reviewing and Learning from the Deaths of Children and Young People.

1.2 The Fife Child Death Oversight Panel* (CDOP) was established in October 2021, in response to the Scottish Government Mandate for developing a national process for reviewing and learning from the deaths of children and young people.

1.3 This is the second annual report for CDOP. The National Hub for Reviewing and Learning from the Deaths of Children and Young People has set out that data should be presented for the fiscal year. As such this report includes data over the 15 months (from 1st January 2023 to 31st March 2024) to ensure alignment to fiscal year reporting going forward.

*Previously title, NHS Fife Review Of Children & Young People Deaths Commissioning Group

[1] https://www.gov.scot/publications/child-death-review-report-scottish-government-child-death-review-working-group/

2.CDOP PURPOSE

2.1 The purpose of the Child Death Review Process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible.

The process intends to;

- Document, analyse and review information in relation to each child that dies, in order to confirm the cause of death, determine any contributory and modifiable factors and to identify learning arising from the process that may prevent future child deaths.
- Ensure appropriate bereavement support is in place for the family.
- Understand what matters to bereaved families and facilitate their voice to be heard as part of the review process.
- Have mechanisms in place to provide feedback to families, and staff involved, the outcomes of any investigation into a child death.
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety, and wellbeing of children.
- To produce an annual report on local patterns and trends in child death, any lessons learnt, and actions taken, and the effectiveness of the wider Child Death Review Process.
- To contribute to local, regional, and national initiatives to improve learning from Child Death Reviews.

3. CDOP MEMBERSHIP AND STRUCTURE

3.1 CDOP is a multi-agency partnership, whose members have differing areas of professional expertise from across Fife. They link with the most relevant team or service to the child or young person to support the review (Table1).

3.2 An ethos of partnership and multi-agency collaboration is at the centre of ensuring high quality learning. As such, this report was produced with input from NHS Fife, Fife Council, Fife Health and Social Care Partnership and Police Scotland.

Table 1.

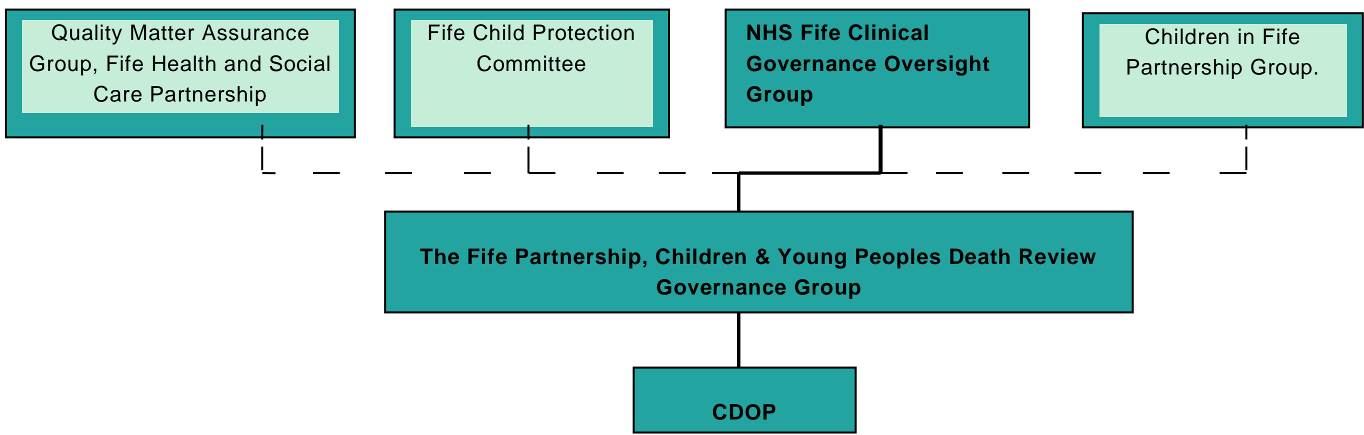
Member	Designation
Lesley Cunningham (Chair)	Child Death Review Co-ordinator
Dr K Aniruddhan (Co Chair)	Consultant Paediatrician/Lead for Child Death Reviews
Christine Moir	Senior Manager, Social Work Education and Children's Services
Linda Sheret	Senior Manager, Children & Families, Fife Social Work
Lindsay Douglas	Lead Nurse Child Protection
Claire Fulton	Lead for Adverse Events - Clinical Governance
Chris Mill	Detective Inspector Police Scotland
Andrew Patrick	Detective Superintendent, Police Scotland
Pamela Galloway	Head of Midwifery and Nursing, Women & Children's Services
Jane Sinclair	Clinical Services Manager (CAMHS)
Lynette Mackenzie	Clinical Services Manager, Paediatrics
Olivia Robertson	Head of Nursing, Health & Social Care Partnership
Laura Stewart	Consultant Neonatologist
Anthony Tasker	Consultant Paediatrician
Yvonne Caie	Bereavement Specialist Practitioner
Ian Campbell	Healthcare Chaplain/Bereavement Lead
April Robertson	CDOP Administrator, Clinical Governance

CDOP Panel Membership – at 30th June 2024

- A requirement of the National Hub is to have a governance group to provide strategic oversight for the Child Death Process. Figure 1. Details the local governance structure.

  The Fife Partnership, Children & Young Peoples Death Review Governance Group meet four times a year, chaired by The Child Health Commissioner and includes senior representation from all the agencies of the partnership.

Figure 1.

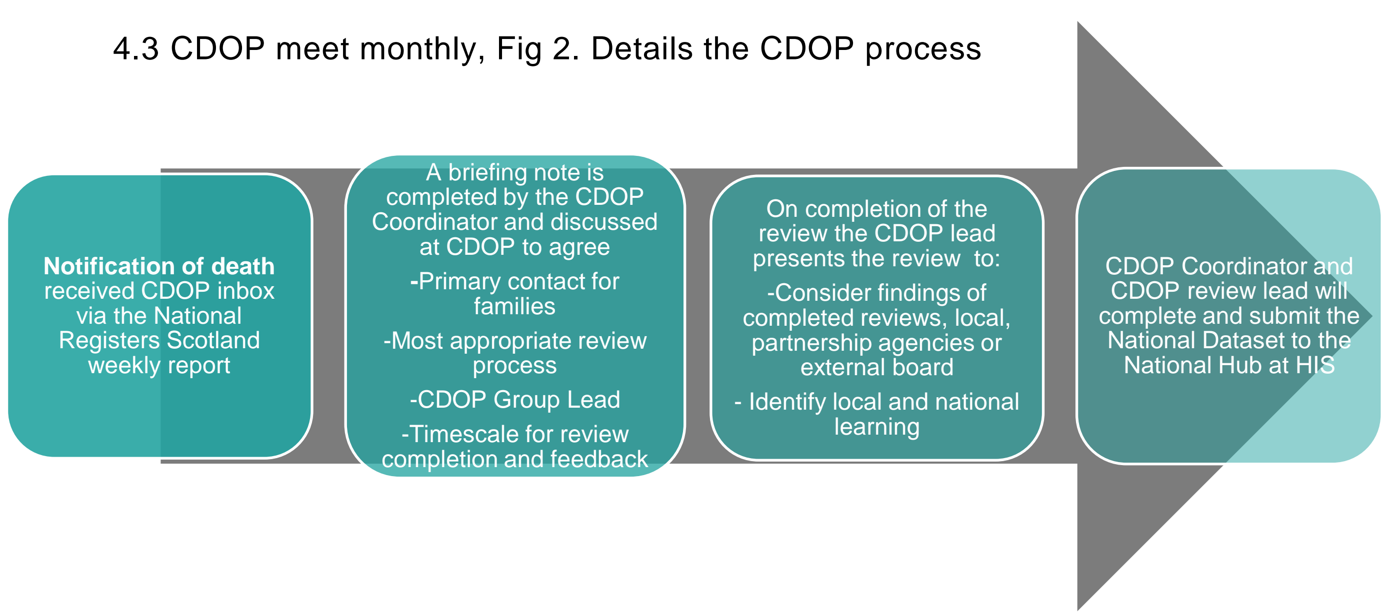


4.CDOP PROCESS

4.1 Reviews are conducted for all live born children after 22 weeks completed gestation of pregnancy and young people up to the date of their 18th Birthday and up to 26 years for care experienced young people actively accessing after care.

4.2 Where a Fife child dies within another health board location, CDOP Coordinator and Clinical Lead work collaboratively with external boards, Child Death Review teams, to complete the review and identify and share learning.

4.3 CDOP meet monthly, Fig 2. Details the CDOP process



4.4 Learning from Process

4.4.1 On completion of the second year of the child death review process in Fife, it became evident that the title of Fife Partnership for the Child and Young Persons Death Review has been causing confusion with families as well as staff across the Partnership. There are numerous different types of potential review depending on the circumstances of a child's death. Whilst these reviews may be called different names, they all share a common purpose of enabling services to learn and make improvements in care and support other families and to prevent future avoidable deaths. The focus of these reviews is learning from what has happened to identify good practice or where improvements might be needed.

Following collaborative multiagency discussion, it was decided to rename the group Child Death Oversight Panel (CDOP)- Learning from the deaths of children and young people.

5.DATA ANALYSIS

5.1 Analysis of Reviews

5.1.1 Included in this report is the 20 child deaths recorded for Fife from 1st January 2023 to 31st March 2024. This includes deaths of children which occurred in a different location but are domiciled Fife. This review does not include children who died in Fife whose permanent address is out with Fife.

5.1.2 The data was provided by the National Registry for Scotland for the children who died in the reported time period.

Data includes, Gender, Age at time of death, Postcode and Cause of death. Due to the time taken to complete a comprehensive review, not all reviews for the time period specified, have been completed, therefore in depth analysis and learning from these deaths will be presented in the 2024/2025 annual report.

5.1.3 It is important to note that the learning from reviews section will focus on completed death reviews from 2022. The reason for this is due to delays in reviews being completed. These delays are multifaceted and include a variety of reasons.

These reasons include, but are not limited to:

- Reporting times for postmortem results and agreement from the Crown Office and Procurator Fiscal (COPFS) that a health and social care review can commence.
- Deaths where Police investigations are ongoing.
- Deaths that require a response first within other established governance structures, e.g., learning reviews relating to child protection processes.
- Capacity issues to undertake reviews in a timely manner. This is a challenge across all Boards in Scotland

5.2 Characteristics of Child Deaths

5.2.1 The data is limited for the deaths occurring during 2023-2024, as a full analysis of the data cannot be shared until all reviews are complete.

5.2.2 The report is also unable to provide figures for the cause of death, or types of reviews that have been commissioned. This is due to the small number of deaths of Fife children and to ensure no identifiable information is shared. Full National Data, which will include the deaths reported in Fife, will be made available in the National Annual Report[2]. It is anticipated that in time as more data is collected, it will be possible to share thematics of the deaths of Fife children.

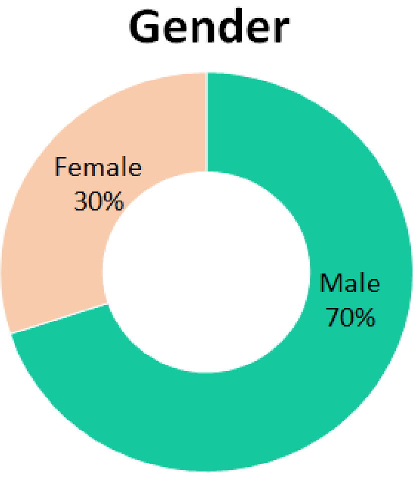
5.3 Gender

5.3.1 There were more child deaths of males than females, with 70% of child deaths occurring in males. Rates varied between males and females within age groups.

All children and young people who died over the age of 14yrs were male

[2] National-Hub-Data-Report-March-2024.pdf (healthcareimprovementscotland.scot)

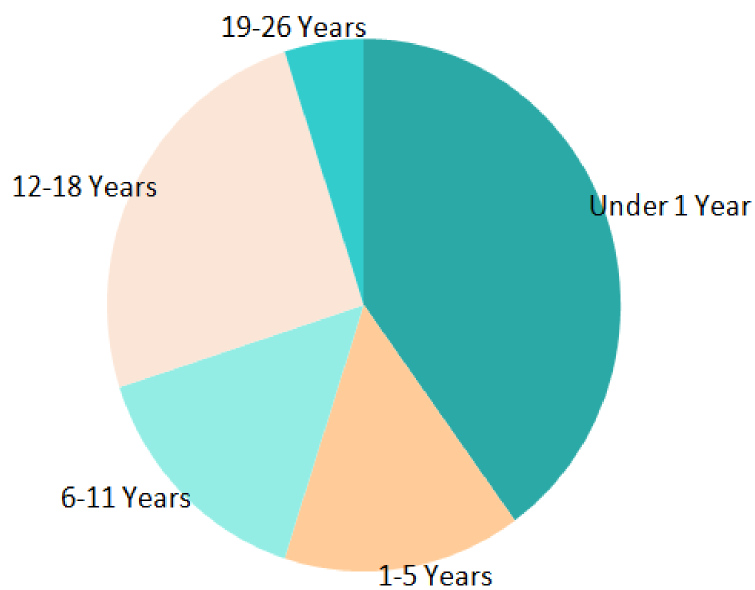
Chart 1: Percentage of deaths by gender classification



5.4 Age Range

5.4.1 Chart 2 below shows the range of ages of the children and young people at the time of their death.

Chart 2: Age of child and young person at death.



5.5 Deprivation

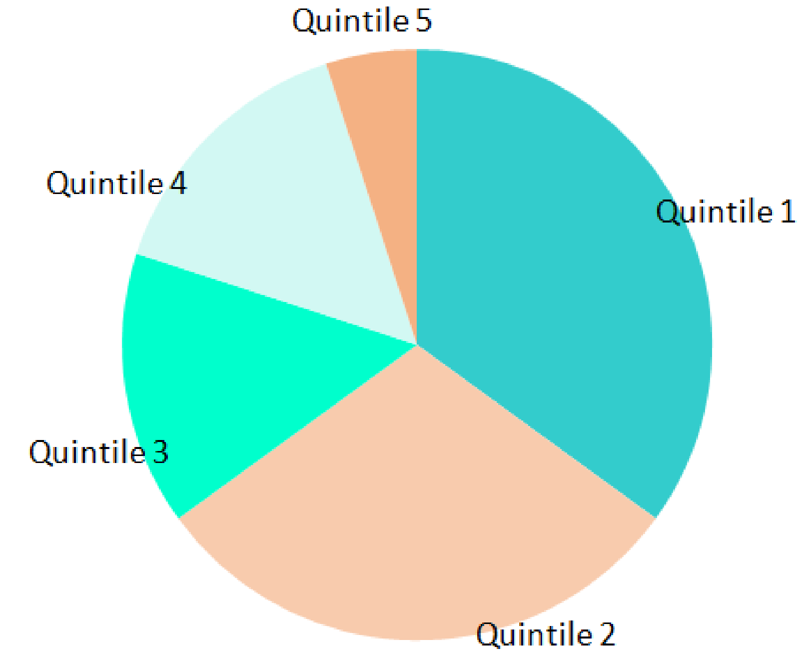
5.5.1 Postcodes from the children and young people's permanent place of residence have been used and not the postcode of the location at the time of death unless the child or young person died at home.

5.5.2 The Scottish Index of Multiple Deprivation (SIMD) 2020v2 has been used to show the proportion of deaths in each quintile. SIMD looks at the extent to which areas are deprived across seven domains: income, employment, education, health, access to services, crime, and housing. Quintile one being the most deprived area and quintile five being the least deprived of areas.

5.5.3 It is widely recognised that pre-term birth, and child deaths including injury are higher in areas of socio-economic deprivation. Chart 3 provides the SIMD quintiles for the 20 deaths within the reporting period.

13 of the 20 deaths were categorised as SMID quintiles 1 or 2

Chart 3: Deaths per Quintile.



6.LEARNING FROM REVIEWS

6.1 Deaths which occurred 1st October 2021 – 31st December 2022 have been fully reviewed and it is therefore possible to include key learning points from these reviews. During this time period there were 28 deaths of children which met the criteria for review. Data sets for twenty of the twenty-eight deaths have been completed and submitted to the National Hub and of these twenty deaths the non-identifiable learning can be shared.

6.2 **The most common causes of death were:**

- Perinatal / neonatal event for children under 1 year of age
- Sudden Unexpected Death – This category is inclusive of Sudden Unexpected Death in Infancy (SUDI), Sudden Unexpected Deaths in Epilepsy (SUDEP), deaths from trauma, deaths where suicide has been suspected and poisoning.
- Chronic Medical Conditions
- Chromosomal, genetic and congenital anomalies

6.3 Modifiable Factors

6.3.1 While there are multiple factors contributing to the deaths of children some of these are modifiable, meaning they can be altered or addressed with the right interventions. By targeting and addressing these modifiable factors progress could be made in reducing mortality rates in Scotland. This report is unable to comment on individual modifiable factors from the small number of deaths of Fife's Children and Young people due to the possibility of identifiable features. This information has been shared for inclusion in the National Report and will allow key strategies to be prioritised by the Scottish Government. Three areas for work below have been identified.

Transition from Paediatric Health Services to Adult Health Services

As children become young adults, they will start to transition to have their care taken overtaken over by adult services. Transition to adult services is a gradual and individualised process. The exact age that transition begins varies according to the various needs of each child and is a multi-agency process. This is in line with the Programme for Government in response to

the United Nations Convention on the Rights of a Child[3]. Key stakeholders in Fife have developed a working group to review and refine pathways for transition for Fife's children into adult services.

Support for Families and Staff

During the last year, CDOP welcomed 2 new additional members, The Interim Head of Spiritual Care and Bereavement Lead for NHS Fife and the Bereavement Nurse Specialist for Women and Children's Service. This has enriched the group by increasing awareness and focus on family bereavement support whilst providing support to the review group.

Staff Support in Neonates

Staff working in the Neonatal Unit are often the ones who witness and experience traumatic responses from parents and families, as well as having to care for unwell babies. One way of meeting the emotional wellbeing needs of staff is to provide debriefs following traumatic events, such as the death of a baby. These can be done in the immediate aftermath of an event ('hot debrief') and a 'cold debrief' is also encouraged (although always optional) in the weeks following an event. This allows time for staff to begin to process what has happened before coming together to reflect.

Over the past year, the Fife Neonatal Unit has tried to prioritise the organisation of debriefs. Cold debriefs are referred to as 'Post Event Reflective Spaces' and are requested by the Charge Nurse. Contact is made with both the Clinical Psychologist (from the Maternity & Neonatal Psychology Service) and the Chaplain (from Spiritual Care). They have found that the joint facilitation of these spaces is the ideal and tailor the format of these to meet the needs of the staff. The overall aim of these spaces is to promote a sense of safety, calming, a sense of self-and community efficacy, connectedness and hope. Feedback from staff has been positive and the hope is that these Reflective Spaces help staff to not only cope with these traumatic events, but also promote the importance of staff emotional wellbeing.

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[3] national-transitions-adulthood-strategy-disabled-young-people.pdf (www.gov.scot)

Trauma Risk Management (TRiM) is the model of support that is used to support officers and staff of Police Scotland who are directly involved in potentially traumatic incidents. Officers and staff can self-refer or ask their Line Manager to make a referral to TRiM on their behalf.

Employees from Fife Council can access a counseling service, Time for Talking, which provides all employees with information, podcasts and self-help strategies as well as access to the Mental Health First Aider Network who provide a listening service.

Children Dying out with Hospital

The National Hub have noted that in circumstances where children have died out with a hospital, with no apparent cause of death, that it could be useful for these children to be assessed by a Paediatrician following the death.

Learning has highlighted that the existing pathway requires optimisation within NHS Fife, Victoria Hospital, to care for the children who have died out with the hospital setting.

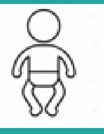
The challenge is specifically around space and location of a dedicated area to provided bereavement support to families and care for the deceased child while investigation commencing into the circumstances of the death. A short life working group was formed including key partners from CDOP and relevant multiagency stakeholders to ensure that a sensitive pathway for the deceased and their families is introduced to NHS Fife.

NHS Fife Bereavement Policy is under review to ensure Fife Wide Policy is applicable to all areas within NHS Fife. This is inclusive of Emergency Department (ED) and Women and Children's Service which is linked to the Child Death Pathway.

7.TRAINING

7.1 Sudden Unexpected Death in Infancy (SUDI) is rare and occurs when there is no known pre-existing condition which could make the death predictable.

Less than 5 of the 20 deaths were recorded as SUDI



7.2 The Scottish Cot Death Trust facilitated a learning event in Queen Margaret Hospital Fife Simulation Training Centre for first responders. This session was a simulation training event where participation was immersive in both the simulation and within the debrief discussion. This allowed for representatives from Scottish Ambulance Service (SAS), Police Scotland and Emergency Department to fully engage in the learning opportunity. This allowed for partnership working and enabled the understanding of each agencies supporting role and procedures.

8. CDOP ACHIEVEMENTS 2023-2024

8.1 CDOP members have welcomed the National Hub information leaflet for bereaved families and have strengthened systems and process to ensure families received this information and have access to the appropriate bereavement support required by them; this includes sign posting to charities and external agencies.

8.2 The inclusion of Spiritual Care and Bereavement Leads in CDOP enables clearer links for family, and staff support following a child death.

8.3 More than half of all children of Fife's deaths in 2023-2024 occurred at another health board location. These circumstances add an additional layer of complexity to the child death review process and accounted for a number of the delays in completion of child death reviews in the 2022-2023 reporting period.

The CDOP coordinator has made connections and built relationships with other board Child Death Review Leads which endeavors to aid timely completion of high-quality reviews whilst ensuring the families are not lost to bereavement support as they navigate a joint board process.

9. CDOP PRIORITIES 2024-2025

9.1 The strive for a single child death review remains a challenge both locally and nationally as parallel processes are often commissioned due to legislative and organisation requirements. CDOP will review and consider local adoption of the guidance from the National Hub published in March 2024[4]

9.2 Training requirements of key members of CDOP will be explored and funded through the Scottish Government allocated funding to strengthen key areas as recommended by the National Hub to improve quality of child death reviews and provide support to bereaved families and staff affected by child death.

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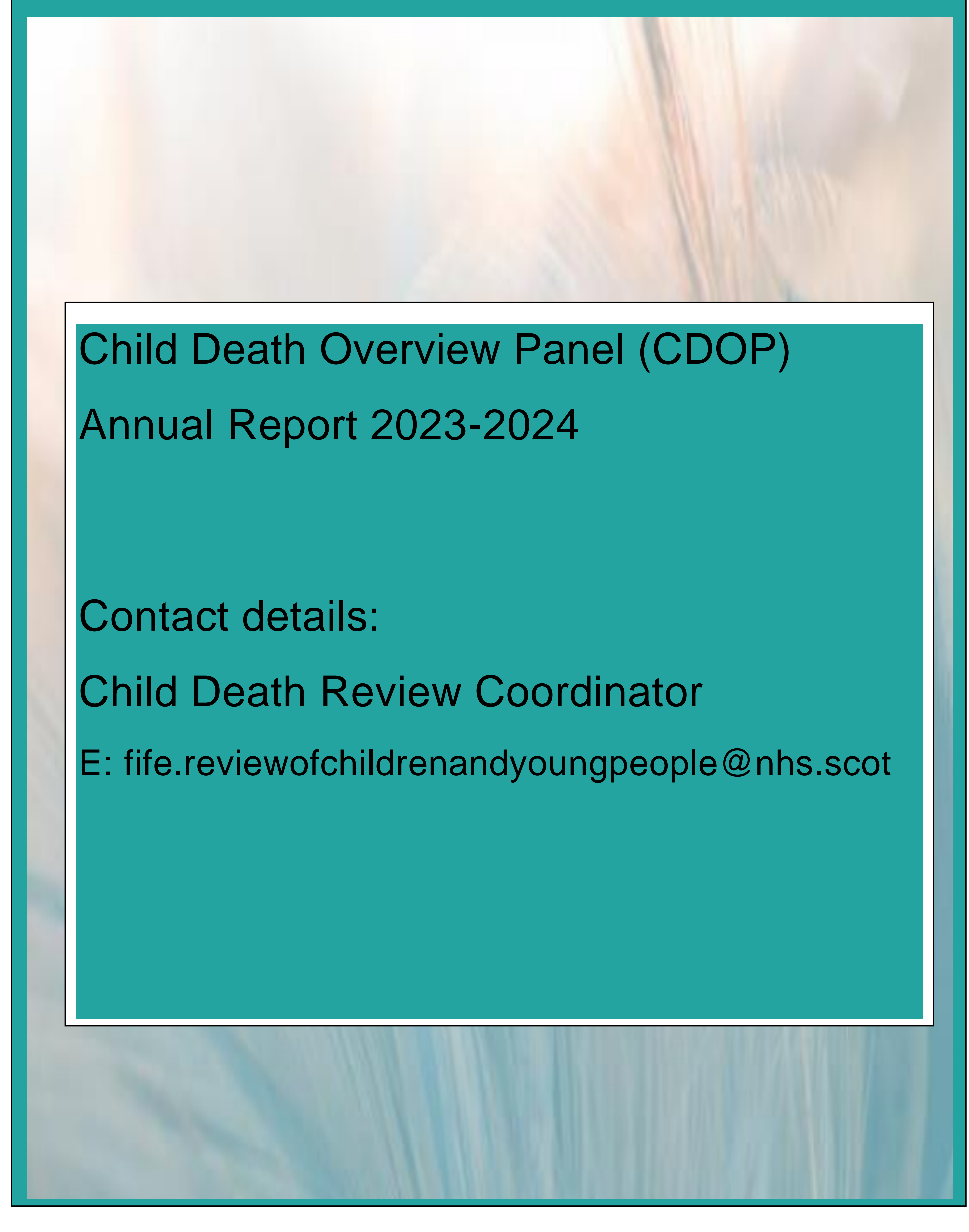
[4] National Hub+COPFS, Consideration of parallel process


Child Death Overview Panel (CDOP)
Annual Report 2023-2024
Contact details:
Child Death Review Coordinator
E: fife.reviewofchildrenandyoungpeople@nhs.scot

AREA CLINICAL FORUM

(Meeting on 1 August 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 1 AUGUST 2024 AT 2PM VIA MS TEAMS

Present:
Aileen Lawrie (Chair)
Aileen Boags, Lead Pharmacist
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Nicola Robertson, Director of Nursing, Corporate
Amanda Wong, Director of Allied Health Professions
Stephen Halstead, Specialist Optometrist

In Attendance:
Susan Fraser, Associate Director of Planning & Performance *(agenda item 5.3)*
Kirsty MacGregor, Director of Communications & Engagement *(agenda item 5.2)*
Rhona Waugh, Head of Workforce Planning & Staff Wellbeing *(agenda items 1 – 5.1)*

The minutes were produced from the recording of the meeting, by Hazel Thomson, Board Committee Support Officer, who was not in attendance at the meeting itself.

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Jackie Fearn (Consultant Clinical Psychologist), Donna Galloway (Women Children & Clinical Services General Manager), Robyn Gunn (Head of Laboratory Services), Ben Hannan (Director of Pharmacy & Medicines), Ailie MacKay (Speech and Language Therapy SLT Operational Lead), Dr Susannah Mitchell (General Practitioner) and Emma O'Keefe (Consultant in Dental Public Health).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 4 April 2024

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum **noted** the updates on the action list.

5. PRESENTATIONS

5.1 Health & Care Staffing Act

The Chair welcomed the Head of Workforce Planning & Staff Wellbeing to the meeting. An update was provided on the Health and Care (Staffing) (Scotland) Act

2019, which took effect from 1 April 2024, and it was advised that a significant amount of activity was carried out to prepare reports for the Scottish Government. The key areas of focus for NHS Fife Board were outlined.

Discussion took place on the challenges around workforce, including the reduced working week, in terms of the requirements for compliance of the Act. It was noted that aspects of the guidance is expected, to take account of the reduction in the working week, and that the circular will be shared accordingly, once available. In terms of good governance, it was agreed that the Board Committee Support Officer link in with the Head of Workforce Planning & Staff Wellbeing regarding progress of the reduced working hours aspect.

Action: Head of Workforce Planning & Staff Wellbeing / Board Committee Support Officer

5.2 Public Participation Strategy

The Chair welcomed the Director of Communications & Engagement. It was advised that a presentation on the Public Participation Strategy and Action Plan was provided to the NHS Fife Board recently, and that the Operational Plan has since been approved. In terms of next steps, meetings will be arranged over the coming weeks to discuss implementation of the strategy, which is primarily in support of some of the immediate Reform, Transform, Perform work that is being undertaken.

The Director of Communications & Engagement gave a presentation on the Public Participation and Community Engagement Strategy 2024-2028. Discussion followed, and it was explained that the pace of implementing change to make efficiency savings will be carried out through engagement, educating and consultation. It was also noted that mitigations will be included in communications, along with questions & answers. Comment was made in relation to the challenges on staff time through implementing change, particularly due to staffing levels. Suggestion was made to share lessons learned in terms of quality of care, and it was advised that Health Improvement Scotland have offered training & development, which was noted as being helpful in terms of learnings from legal cases. An overview was provided on the action plan, including expected timescales for projects, and it was advised that an audit will be carried out for service user groups within the coming weeks.

A request was made for volunteers for Engagement Champions. Further detail will be issued.

Action: ACF Members / Board Committee Support Officer

In terms of good governance, it was agreed that the Board Committee Support Officer link in with the Director of Communications & Engagement regarding progress on delivery of the Public Participation and Community Engagement Strategy 2024-2028.

Action: Director of Communications & Engagement / Board Committee Support Officer

5.3 Population Health & Wellbeing Strategy Annual Report & Annual Delivery Plan

The Chair welcomed the Associate Director of Planning & Performance to the meeting. An update was provided on the contents of the Population Health & Wellbeing Strategy Annual Report, noting that the public information data is from 2021/22, however, supports identifying key trends. An overview was also provided on the case studies, and the ambitions for each strategic priority was highlighted.

In terms of the annual delivery plan, it was reported that improvements will take time to embed as the strategy is only in year one. However, it was advised that positive progress is being made. It was highlighted that the strategy is flexible and will take account of the Reform, Transform, Perform work that is ongoing, whilst also linking to our ambitions and strategic priorities. In terms of progress of the strategy, it was agreed that input from the wider clinical community would be helpful, and suggestions or issues were welcomed. The Chair agreed to take this forward as an action.

Action: ACF Chair

It was reported that the Annual Delivery Plan has been agreed by the NHS Fife Board, and that the Scottish Government had reported that the plan broadly meets their requirements and provides appropriate assurance under the current financially challenged landscape. It was noted that the quarter one return to the Scottish Government will highlight that the plan is dependant on funding, and it was agreed to be shared with the Forum, once it has been through the governance routes.

Action: Director of Planning & Performance

The Chair agreed to discuss with the Director of Planning & Performance, outwith the meeting, on the potential to hold a Forum Development Session on the Annual Delivery Plan.

Action: ACF Chair / Director of Planning & Performance

6. STRATEGY / PLANNING

6.1 Scottish Government Rehabilitation Plan

The Director of Allied Health Professions reported that the Scottish Government Rehabilitation Plan was published in 2022, and that it underpins the work within Fife around Home First and aspects of the community hospital modelling. It was noted that an oversight group is being considered, to ensure that the principles within the framework are upheld.

It was agreed a further update will be provided to the Forum, once available.

Action: Director of Allied Health Professions / Board Committee Support Officer

7. QUALITY / PERFORMANCE

7.1 A Shared Governance Model in Nursing and Midwifery

The Director of Nursing gave a presentation on Shared Governance / Shared Leadership. Discussion followed in relation to multiprofessional work, and it was highlighted that consideration is required in terms of responsibilities.

Feedback was requested from the Chair from the local government authorities on the work that is being undertaken, and any support requirements.

Action: Director of Nursing

8. UPDATES FROM EXTERNAL GROUPS

8.1 Area Clinical Forum Chairs Group for Scotland Update

It was reported that an update will be provided at the next meeting.

9. GOVERNANCE MATTERS

9.1 Delivery of Annual Workplan 2024/25

The Forum took **assurance** from the workplan.

10. LINKED MINUTES

10.1 GP Sub Committee held on 21 May 2024 (confirmed)

10.2 Area Medical Committee held on 11 June 2024 (unconfirmed)

10.3 Healthcare Science Forum held on 3 June 2024 (unconfirmed)

10.4 Area Pharmaceutical Committee held on 22 April 2024 (confirmed)

11. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no matters to escalate to the Clinical Governance Committee.

12. ANY OTHER BUSINESS

12.1 Annual Review

It was reported that the Annual Review will take place on 30 September 2024, and will be a ministerial visit. Members were encouraged to attend, or send a deputy, to represent the Forum. It was agreed an email will be issued to members with the details.

Action: Board Committee Support Officer

13. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 3 October 2024** from 2pm – 3.30pm via MS Teams**.**

AREA MEDICAL COMMITTEE (Meeting on 11 June 2024)
No issues were raised for escalation to the Clinical Governance Committee.

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 11 JUNE 2024 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Fiona Henderson	Fife LMC Honorary Secretary
Glyn McCrickard	Fife LMC Representative
Ian Fairbairn	CD, Medical Directorate
Morwenna Wood	AMD, Medical Education
Sally McCormack	AMD, Medical & Surgical Directorate
Shirley-Anne Savage	Associate Director for Risk & Professional Standards
Susanna Galea-Singer	Clinical Lead for Addictions (from 2.30pm)

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Apologies were received from Claire MacIntosh, Iain MacLeod, John Morrice, Joy Tomlinson, Susie Mitchell

CALENDAR INVITE DECLINED

Jackie Drummond, Helen Hellewell, Robert Thompson

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON

The notes of the meeting held on 09 April 2024 were approved as a correct record of the meeting.

4 MATTERS ARISING

i) **Stand Up Secondary Care Medical Staff Committee**

Chris McKenna advised he and Iain Macleod have been unable to progress this further.

ii) Chris McKenna advised he has invited Shirley-Anne Savage in her new role as Associate Director for Risk and Professional Standards to join the Committee. The professional standards part of her role supports several important areas of work covered by the Office of the Medical Director which includes the AMC and would allow her to support any work that arises from the Committee. The current Constitution will be amended to reflect this

It was also agreed the Constitution would be renamed Terms of Reference.

Action: SAS

In line with the current arrangements, it was noted Susie Mitchell would take over as Chair of the AMC from August 2024. Chris McKenna agreed to follow this up with Susie Mitchell.

Action: CMcK

5 STANDING ITEMS

i) Financial Position – Including *(IPQR)*

Chris McKenna advised the financial position remains challenging with the focus being to address the 7% gap. Work is underway to deliver the first part of this which is the 3% gap and at month one the position is good but not quite where we need to be. Most of the savings are in relation to the reduction of medical and nursing agency work. There are also significant areas of overspend in relation to medical locums and this is also being looked at to see what improvements can be made. The main outlier remains Psychiatry.

It was highlighted there had been a change in the IJB financial situation due to the £5m overspend in Adult Social Care. This has an impact for the Board because of the risk share agreement and resulted in the year end accounts being revised.

Fiona Henderson commented it was good to see progress has been made in terms of the financial position but from the GP Sub position there is frustration around the delays in recruitment that are occurring because of the new recruitment process. Ring fenced funding is available for Primary Care, so the money is available, but still AHP posts are having to follow the same recruitment process as other posts. Dr McKenna recognised the frustration expressed and said there were a number of ring-fenced budgets within the organisation which are currently being revisted by the Director of Finance. He agreed to pass on the feedback.

Dr McKenna gave assurance that he has advocated fast tracking posts that are already covered by locums, but this is something that will take time to improve.

Sally McCormack also echoed the frustration from secondary care around recruitment and said the speed and transparency of the process has been lost and it would be helpful to have a clear workflow.

Fiona Henderson highlighted aside from recruitment there seems to a change to GP reimbursement claims which is also causing frustration given it has already been agreed that Locum reimbursement will be paid for attendance at meetings.

In closing Chris McKenna said everyone will be experiencing the consequences of how the organisation saves money and gave assurance he will continue to challenge the effectiveness of the process especially if it compromises safety of patient care.

ii) Adverse Events Update

Dr McKenna suggested it would be helpful to invite Claire Fulton to attend a future AMC meeting to provide an update as the process for adverse events reporting has recently been refined and the criteria for major and extreme harms has been redefined in relation to commissioning of significant adverse events.

iii) Medical Staff Committee

Nil to report.

iv) Update from GP Sub Committee

Chris McKenna advised that the GP Sub has discussed the issue of methotrexate no longer being prescribed. Sally McCormack reported that she has prepared an SAR which is now being taken forward by Aylene Kelman and Rheumatology to ensure that the shared care agreement is up to date. They have been told explicitly support will be removed unless the policy is up to date.

Fiona Henderson said it would be helpful to ensure this information is filtered through to all Rheumatology Consultants to make them aware a new policy is in place. Sally McCormack said there was support from within VHK, for a one shared care policy for all specialties and was happy this stance had been taken.

Fiona Henderson said there is no significant improvement in provision of the GP contract and there is a lack of direction from Scottish Government of what can be done when the contract is not being provided in 2024-25.

Glynn McCrickard highlighted that the BMA have provided guidance around GP workload and said in lieu of forthcoming support around the contract from SGHD and the failure of the GP contract and an inability for SGHD to define what GPs should and should not be doing to operate safely, they have taken medical legal advice to the effect that GPs should safely limit their workload to twenty five fifteen minutes patient contacts a day or equivalent.

The consequence of this may be patients will be directed to out of hours and if it is an emergency then the patient has the option, if they consider it an emergency, to approach the emergency department (ED).

Sally McCormack said it was good for secondary care to be aware patients are being diverted to OOH but is concerned patients may attend ED that

are not accidents or emergencies. The ask would be that if patients are approaching their GP that it is OOH, they go to and should only be coming to secondary care if needing A&E. It would also be important from a governance point of view to be aware of any increase in numbers and report how often this is happening.

In closing Chris McKenna said if patients turn up at A&E with non-A&E issues the expectation would be the redirection policy should be invoked and patients would be redirected back to Primary Care. The situation should be monitored, and it cannot be underestimated the significant pressure that unscheduled and ED care are impacted on every day. This is representative of the pressures general practice face too. Consideration should also be given to the impact this may have on reputation and therefore thought should be given to how this can be achieved without impacting negatively on the reputation of general practice. Chris McKenna agreed to pick this up with Helen Hellewell, the Primary Care Team and Comms to ensure a positive supportive message is circulated.

Action: CMcK/SAS

v) Realistic Medicine

Chris McKenna advised there had been a good meeting on how to start progressing RM. It was agreed feedback should be sought from the public to gauge what their understanding is around the basics of realistic medicine. The previous survey which was circulated was too long and wordy so a revised survey will be circulated to staff and the public to try and identify where there may be gaps in knowledge or understanding. It is hoped this will then allow detailed ideas to be explored through small focus groups of people.

The work being undertaken by the realistic medicine team will also align with the RTP work being carried.

vi) Medical Workforce

Chris Mckenna advised there was no significant update.

It was noted Dr Rob Cargill has returned to Fife and is now working as an Acute Physician.

Sally McCormack advised nine more Gateway Doctors were coming in at FY1/FY2 level for the next two years. The programme is still in its infancy and the doctors will only rotate through Medicine, Surgery, Women and Children's, ED and ENT. It is hope this will continue and there is no reason why in the future the FY2s could not be rotating into Psychiatry where there are gaps.

Sally McCormack advised that this has been a lot of work and very complex and there will probably be the need to create a Training Programme,

Director type post. There is potential and it has been successful for far. There remains a lot of gaps and these are being worked through. Dr McKenna acknowledged and thanked Sally McCormack for her hard work in getting this set up.

It was noted that the ADMEs in Medical Education would have an overarching role in this programme.

It was noted there has been progress within Radiology with a few Radiologists being appointed.

Fiona Henderson said General Practice would be happy to have FY2s as it is almost impossible to get them from Tayside or Lothian. Sally McCormack advised there are no spare FY2s but if Practices were willing to pay for Gateway FY2s then they were available. Dr McKenna advised he is looking into the current complex situation in relation to Tayside FY2s. Conversations are underway with NES to address this.

Susanne Galea-Singer advised it would be good to have FY1s in Psychiatry. There are still quite a few locum positions, and this is being worked on to move those to substantive posts to provide more stability within both Psychiatry and Addictions. Chris McKenna advised there is a specific concern in relation to Locums within Psychiatry and a bespoke piece of work is required, probably Nationally, to try and address this complex problem.

vii) Education & Training

Chris McKenna advised it will be announced later this week that we have achieved the numbers for ScotCOM. 36 were required and we have 43. These numbers attract the funding and will help in solving recruitment to trickier areas. The first student will start in January 2026, so there is a year and a half to align our recruitment plan.

Chris McKenna advised we have written to the SGHD, who are taking legal advice, about changing legislation to make Fife one of five Teaching Health Boards alongside Glasgow, Tayside, Aberdeen and Lothian.

Sally McCormack advised the three main medical rotas were non-compliant and Iain MacLeod and Caroline Bates have been working on this. This is a complex process which involves redesigning a rota, seeking junior sign off and then submitting to NES. Once NES return the rotas they are then sent to SGHD. The cut off for submission is next week.

It was also noted;

- surgical rotas are all narrowly compliant
- FY1 junior rota supplemented and complaint

- intermediate surgical rota is not being rewritten as present as it is very complex but if it can get to one in eight should be compliant
- Women & Children rota is being worked on.

The hope is to have the potential to be completely compliant by August 2024. There needs to be an awareness that the hospital will be changing so a lot of staffing is based on what is anticipated alongside the RTP pressure to get it right.

It was noted currently limited assurance can be given to the board that we will be able to deliver. The focus is to ensure rotas are complaint and staff are supported to ensure they remain complaint. This may involve a change in culture to achieve.

viii) Update from Division of Psychiatry

Susanna Galea-Singer advised there is no major update other than capacity issues and unscheduled care processes.

6 STRATEGIC ITEMS

i) GMS Implementation

Fiona Henderson advised there was no update as the contract still was not implemented. It was noted the second transitionary payment was received in May for last year so the underspend was divided among the Practices to reflect that practices were continuing to employ staff the H&SCP should now be producing. H&SCP Leads have advised they are awaiting confirmation from SGHD to decide what to do this year as they had undertaken a test of change in pilot areas. Fife did apply to become one but were not selected. There are four areas in Scotland where SGHD are putting in money to see what it would cost to do a fully implemented contract as they originally suggested. The focus is now going to be on these places, two of which are local, so there is a concern this may potentially attract staff away from Fife.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee: 19 March & 16 April 2024

Noted.

ii) Notes of the Clinical Governance Oversight Group: 16 April 2024

Noted.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 17 April 2024**

Noted.

8 AOCB

8.1 RTP

Dr McKenna suggested RTP be added to the agenda and Ben Hannan invited to attend meeting to give an update.

9 DATE OF NEXT MEETING
13 August 2024 at 2pm via MS Teams

RADIATION PROTECTION COMMITTEE

(Meeting on 9 May 2024)

No issues were raised for escalation to the Clinical Governance Committee.

RADIATION PROTECTON COMMITTEE MEETING
Via Teams
Wednesday, 9th May 2024
10.30am – 11:30am

Present:
Dr Chris McKenna (Chair)
Nicola MacDonald, RPA, Head of Radiation Protection
Debbie Slidders, RPS, Public Dental Service
Emma Hall, Quality and Education Lead for NHSF, RPS
Joanne Hogarth, X-ray Clinical Service Manager, RPS
Andy Ballantyne, Clinical Director for Orthopaedics
Lesley Henderson, X-ray Clinical Service Manager, RPS
Kate Sexton, Clinical Scientist
Richard Scharff, Radiology Manager, Deputy RPS for NM
Jane Anderson, General Manager for Women and Children's Clinical Services
Clare Parry, Clinical Scientist
Gill MacNaught, Lead MRI Physicist

1. Apologies:
Nick Weir, Consultant Physicist
Simon Willis, RPA, RWA
Tom Hartley, Clinical Lead for Radiology
Cath Jack, Theatres Manager
Louise Kroegler, Clinical Director for PDS
Michelle Rooney, Clinical Scientist in NM

2. Minutes of previous meeting
- These were unavailable.

3. REVIEW OF ACTION PLAN:

MRI Scanning / Pacemakers
JA noted that there is a business case that outlines the requirements to fulfil this service but it needs some financial investment. It has been on the annual delivery plan for two years and hasn't been a priority. There are other boards in Scotland which do not deliver that service either. A couple of the bigger boards provide the service, but they don't offer access to other boards. Only one complaint has been received from a patient who thought he should have had an MRI. It would be a great service improvement for the population of Fife but in terms of the other priorities just now, there is no finance to support it.

Radon Assessment for underground workers
Remediation work has taken place at Kinghorn and a second round of monitoring is currently taking place. Results are expected by July.

Two sealed disks, sources for dose calibrator QC at QMH
After reviewing the QC procedures it was agreed disc sources were no longer required.

Review of Supply of Dose Monitoring Badges

There is a plan of action for NHS Lothian which is to move the non-classified workers with low doses (those being monitored quarterly) to a new supplier: UKHSA. This will be trialled in Lothian first, and if the service and reporting is of a good standard then Fife staff would also be moved to this supplier at the start of next year. There will be no additional cost to the organisation as a result of this change.

Classification of NM Workers
There was a member of the occupational health team in NHS Fife who was training to be the appointed doctor. However, they are no longer with the organisation, therefore the plan is for NHS Fife to engage the NHS Lothian appointed doctor to carry out the medical exams to allow this staff group to be classified. This will affect around 6 members of staff and the expectation is for the process to begin in July.

AGENDA ITEMS:

4. Annual Compliance Reports

Radiology

- 7 responses from Radiology covering general x-ray, fluoroscopy, nuclear medicine, CT and mammography.
- No issues were raised.
- The consensus was that management take an active role in promoting radiation safety culture across NHSF and there is an excellent partnership with NHS Lothian and the medical physics team.
- There was a request to have more regular on-site contact with medical physics so this will be followed up.
- There was good knowledge and application of the local rules.
- There is an RPS training date scheduled for 23rd May to train more staff to help manage radiation protection across the service.

Dentistry

- The responses to the audit form didn't highlight any issues.
- Two OPG units have recently been replaced and staff are in the process of getting trained so the units can be used clinically.
- Big project this year is moving from film to digital imaging.

Theatres

- No representative from theatres at the meeting but the online audit form had been completed.
- No issues were raised in the form.
- It was noted that much stronger relationships with medical physics are now evident with training, support and advice.

Dermatology

- No representative from dermatology at the meeting but the online audit form had been completed.
- No issues were raised in the form.

Staff Dose Report

- Staff doses are very well controlled in NHS Fife with 87% of staff receiving whole body doses below the annual investigation level and 100% receiving extremity and collar doses below the respective annual investigation levels.
- The 13% of staff above the whole body annual investigation level comprised 24 members of staff. 23 of these were due to either transit irradiation exposures or the use of an inappropriate control by Landauer and are not true occupational doses. The last member of staff is from Nuclear Medicine and their dose is the sum of several smaller doses accrued through out the year and is due to the fact that this person works in the department 3 or 4 days a week compared to the one day a week that the other staff members work.
- PDS doses are covered in the environmental report but are also well controlled.
- The report recommends that when doses exceed a monthly investigation level, that the RPS submits a Datix report at the time so it can be investigated promptly, and this will be covered in the RPS training.

Radiation Incident Report

- 129 ionising radiation incidents in 2023, which is 0.05% of the total exams performed.
- 14 of these were notifiable, which is 0.005% of the total exams performed.
- Only 3 of these involved members of staff:
    - A student practitioner who received a whole body dose of 1.99mSv which could not be accounted for by the badge being misplaced or scanned at the airport so had to remain on the record.
    - One where a member of staff wore their badge outside their lead apron instead of on the inside and is not representative of a true occupational exposure.
    - One where staff were setting up the interventional suite for the next procedure without any PPE on and someone accidentally stood on the exposure pedal irradiating the staff inside the theatre.

- 13 MRI incidents in 2023
    - All near misses to do with inappropriate referrals
        - 11 pacemakers
        - 1 programmable shunt
        - 1 aneurysm clip
    - Well done to staff for catching the incidents.
    - SCIN group have been looking at referral questions nationally to determine if repeat questions can help. Gill will review this work and feedback.
    - MRI physics team have developed an MRI safety page with they are sharing with the clinical departments and this includes training material for referrers.

Environmental Dose Monitoring

- Environmental monitoring took place in 5 rooms across NHS Fife and there were no areas noted to exceed the annual radiation dose constraint.
- There were a further 5 shielding assessments completed to confirm the level of shielding present in the existing walls and no issues were highlighted.
- There has been a review of the records of shielding in NHS Fife and there are 6-8 rooms which require confirmation and will be assessed.
- C-arm doses are monitored to give an indication of staff doses in theatre. The maximum dose recorded was 2mSv but because staff in theatre will not be present for every case, will be around 1m from the badge location and wear full PPE then staff doses are estimated to be around 5% of this number which provides reassurance that doses are low and well controlled.

- Public Dental Service staff are also monitored via environmental badges and none of these exceeded any dose investigation levels which indicates these staff are subject to very low levels of exposure.
- No passive monitoring was performed in nuclear medicine in 2023 but there is a wider plan that will include passive monitoring, dose rate monitoring and wipe testing around the controlled area and this will be initiated in 2024.
- Overall, there is no cause for concern.
- It should be noted that if any member of staff notes any damage or changes to any of the barriers, e.g. estates doing work to the walls, then please let medical physics know so the integrity of the shielding can be verified.

5. Orthopaedic surgeons and PPE (AB/NMD)

- There has been a journal article that highlights the possibility of female surgeons having a higher prevalence of breast cancer and this has caused concern among staff.
- The concern is that certain types of axillary breast tissue are not being adequately protected by the PPE available.
- There have been suggestions to remove the tabard style lead aprons in favour of wrap around aprons, as well as purchasing additional PPE.
- NMD noted that the key thing is for NHS Fife to have adequate PPE available – this means a range of sizes for staff to choose from so they can select an apron which has a close fit around the arm holes.
- NMD also noted that in terms of radiation protection, there are 3 main principles – time, distance and shielding and shielding is the last step to reduce dose. The first 2 are the easier options and there should be a focus also on training: ensuring x-rays are only taken when they are required; if staff can, then they should be encouraged to take a step back during the exposures and on the proper fitting of PPE.
- It was agreed that an audit of existing PPE and the number of female surgeons affected would be undertaken lead by AB/RS/CL.
- KS is performing live dose monitoring in theatres in NHSL and can feedback the results to help with the PPE review - there is no need to replicate the work in NHSF.

6. Optical Radiations Policy (KS)

- NHS Fife optical radiation safety policy has been drafted.
- It will be circulated to the LPSs, dermatology and the laser team and comments are required by mid June.
- It will be presented at the next policy committee which takes place at the end of June.

7. Escalations from expert advisers

- RPA - none
- RWA - none
- LPA
    i. Any move of the lasers to a different location should be notified to the medical physics team.
- MRSE
    i. The MRI safety policy is being developed for NHS Fife.

8. Any other Business

- NMD noted the risk to the phototherapy service if medical physics support was not agreed. CM noted that it had been escalated to the director of acute services.

9. Date of next meeting

7th of November 2024 2-3.30pm

CLINICAL GOVERNANCE OVERSIGHT GROUP

(Meeting on 20 August 2024)

All escalations are noted as part of the Clinical Governance Oversight Group Assurance Summary.

Date :	20/08/2024
Enquiries to:	April Robertson
Telephone Ext:	Microsoft Teams

UNCONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 20th AUGUST 2024 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Director of Nursing, HSCP
Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Gemma Couser (GC)	Associate Director of Quality & Clinical Governance
Dr Stephen Fenning (SF)	Associate Director of Medical Education
Fiona Forrest (FF)	Acting Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Robyn Gunn (RG)	Head of Laboratory Services
Janette Keenan (JK)	Director of Nursing, NHS Fife
Aileen Lawrie (AL)	Director of Midwifery
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr Iain MacLeod (IM)	Deputy Medical Director, Acute Services Division
Dr Chris McKenna (CMcK) (Chair)	Medical Director, NHS Fife
Dr John Morrice (JM)	Associate Medical Director of Women & Children
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Nicola Robertson (NR)	Director of Nursing, Corporate
Shirley-Anne Savage (SAS)	Associate Director for Risk & Professional Standards
Gavin Simpson (GS)	Consultant Anaesthetics
Amanda Wong (AW)	Director of Allied Health Professions

In Attendance

Susan Fraser (SF)	Associate Director of Planning & Performance
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Benjamin Hannan (BH)	Director of Reform and Transformation
Dr Helen Hellewell (HH)	Deputy Medical Director, Health & Social Care Partnership
Dr Sally McCormack (SMcC)	Associate Medical Director for Medical & Surgical Directorate
Prof Morwenna Wood (MW)	Director of Medical Education

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 18th June 2024**	
	The Group confirmed that the note from the meeting held on the 18th June 2024 was an accurate record.	
3	**Matters Arising/Action List (CMcK)**	
3.1	SBAR NHS Fife Duty of Candour Process	
	GC informed. this paper outlines a draft proposed procedure to be undertaken across Acute Services Division and Health & Social Care Partnership for Duty of Candour	

	(DoC) with particular reference to the process of providing a letter of apology. This paper builds on the paper which was presented to Clinical Governance Oversight Group in October 2023. There wasn't a consistent tone in letters going to patients and / or families. The letter of apology template should be updated to ensure a sincere and heartfelt apology which speaks to the person(s) is drafted. Currently a potential DoC activation is identified by review teams through adverse event or complaint processes. The case is then sent to the Medical Director to determine if DoC is to be activated. Further to review of the extant process the following recommendations are made in order to streamline the process, improve a timely apology being issued and implement quality performance indicators to measure adherence with the legislation. A rich discussion followed from members around how there wasn't a consistent tone in letters going to patients and / or families. The letter of apology template should be updated to ensure a sincere and heartfelt apology which speaks to the person(s) is drafted. The group welcoming of this guidance. This approach should now provide a consistent approach across NHS Fife.	
3.1.1	DRAFT NHS Fife Duty of Candour Procedural Guidance	
	CMcK asked the Group to provide GC with any comments / feedback. This will be brought back to the next meeting for final sign off.	**GC**
3.2	SBAR NHS Fife Health & Social Care Partnership Complaints Timescales	
	LB explained the paper aims to give a moderate level of assurance to NHS Fife Clinical Governance Oversight Group regarding performance of HSCP complaints performance. Various challenges have caused problems in meeting compliance targets. These include, staffing issues; training issues; and a need to ensure collaborative working in responding. It has been identified that a more robust process is required to ensure organisational learning from complaints is in place. Delays in complaints process have a negative impact on patients and their families however the processes above are demonstrating thorough review and quality in response. Work continues to improve the patient experience around complaints and to take learning from same to improve the care experienced. A healthy discussion followed around timescales and the various reasons behind them, particularly the escalation process. SM is currently working on a paper on the escalation process and will circulate a draft around members.	**SM**
3.3	NHS Fife Clinical Governance Oversight Group Terms of Reference **(GC)**	
	GC spoke to the Terms of Reference (ToR) and pointed out; the key changes were around the membership of the Group. GC asked the group if we should consider Digital & Information representation. She asked the group to note that there was an update to the 'Role & Remit' to focus more around the learning as well as the addition of the assurance reports which now come from the acute services division and Health & Social Care Partnership CMcK asked for feedback / comments to be sent to GC, the final ToR will be brought back to October's meeting for sign off.	

		GC
4	**GOVERNANCE**	
4.1	NHS Fife Integrated Performance Quality Report	
	CMcK noted there had been many changes to the Integrated Performance Quality Report (IQPR) he went on to say that this document is one of the primary ways we provide quality and assurance to the Board. The challenge he wanted to put the group was, are we comfortable with this, and the reporting. He also wanted to understand the governance of agreeing the 'local targets' when there are national targets in place. NB explained that with regards to falls the "Safer Mobility & Falls Oversight Group", they looked at the national target and what the NHS Fife data was and agreed on targets which were achievable. These are updated incrementally each year after looking at our past performance. She feels the organisation has a well-informed decision in target setting. CMcK responded that he was aware how these targets are decided however, where is the paper that shows / explains this process for governance. He wondered what the national target was, as it was not noted in the IPQR document. NR agreed that it would be helpful to have both the local and the national target held within the document. She thought there was no governance around how / why this figure was derived. SF informed that group that there had been an ask from the Executive Directors Group (EDG) last week that we use national targets within the IPQR. Therefore, this can be reflected within the summary scorecard but then within the detail we can separate between the local and the national targets. CMcK asked if they could look at the Quality metrics and look at whether our local targets ensure that we are able to fully explain and rationalise why they are there. After some discussion, SF & CMcK agreed a paper which documents where local targets have come from and how and by whom they are 'signed off' would be brought back to October meeting	SF
4.2	SBAR NHS Fife Health & Social Care Partnership Clinical Governance Assurance Report	
	LB informed the group that this SBAR relates to Fife HSCP Quality Matters Assurance Group Clinical Quality (QMAG) meeting on 17th May and the interim Quality Matters Assurance Safety Huddles (QMASH). There were no escalations, however, it was worth noting that there has been a sharp rise in medication incidents in community care services. This may be due to the significant amount of support following an incident in the community setting. Staff were becoming much more vigilant in reporting. CMcK had noted that within Mental Health and Learning Disabilities there was an increase in ward-based incidents involving the use / attempted use of a ligature (upward shift from August 2023 to February 2024). The rate of restraint also increased from September 2023 with an upward shift occurring (median rate is 6.80).	

	The rate of self-harm incidents reported was below the median between December 2023 and March 2024. CMcK asked if there was a response to this CG responded that there were regular reports around ligatures, a response is expected at the next QMAG meeting (30th August 2024) There are also regular updates to service from the "Ligature Groups".	
4.3	SBAR NHS Fife Acute Services Division Clinical Governance Quality Assurance Report May 2024	
	NB spoke to the assurance update which relates to the NHS Fife Acute Services Division (ASD) held 24th July 2024, he highlighted the following points. **Waiting times** From the waiting time report it was noted waiting times and waiting list size continue to increase month on month for both outpatients and inpatients / day cases. Demand is increasing and is now greater for both outpatients and inpatients / day cases than in 2019. Waiting Times continue to be discussed at each of the Directorate Performance Review **Tissue Viability Annual Report** The Director of Nursing highlighted from the Tissue Viability report the significant amount of work undertaken over the last year. The team have developed links with University of St, Andrews, and University of Dundee to develop and deliver education to nursing students. The team are looking to adopt the National trigger for Adverse Events, this will mean that any Grade 4 Tissue Viability incident will trigger a SAER. **Woman, Children & Clinical Services** **Badgernet** Business Analyst support for digital transformation, there is currently no support in place. There is an ongoing risk with the interface for Laboratories and scans, this is sitting on the risk register. Mrs Lawrie has met with Mr Graham and work will be taken forward by the Digital team. **Staffing** within neonatal continues to be an issue due to long term absences with the Neonatal Training Nurses **Spotlight Report - Extravasation** An excellent presentation was given by Mrs Bonellie, radiographer summarising the current and previous rates of extravasation in CT. There was discussion around the risk of extravasation and how those risks can leave CT particularly vulnerable. The conclusion highlighted the improvement work that is taking place at a departmental, organisation and national level. **Surgical** **Insufficient Trauma Theatre Capacity** NHS Fife is a negative outlier (-3SD) for time to theatre within 36 hours for hip fracture patients. NHS Fife, consistently > 5 years, has not attained the key performance indicator 6: Time to theatre < 36 hours. IM gave and update of a new development since the Acute Services Division, Clinical Governance Committee meeting which he felt should be escalated formally to this group. There are local actions in place to deal with Insufficient Trauma Theatre Capacity. An expedited action plan is currently underway ahead of a meeting with an external review team in October CMcK stated that we needed to provide assurance to the external review team	

	around this complex issue. A decision can then be made whether this needs escalation. CMcK also wanted to point out from the Assurance Report; **Spotlight Report - Co-Located Respiratory Unit** Dr Fairbairn presented a spotlight report, and the following points were noted: • Respiratory currently operate from Wards 43 & 51 • There is a move nationally to set up Acute Respiratory units where units specialise Respiratory support. • Ward 43 will move shortly up to Ward 53. Although the move comes with lots of benefits for the team, there is also the loss of 6 beds.	
4.4	NHS Fife Clinical Policy & Procedure Update 24th June 2024	
	EM advised at the 24th June 2024 meeting of the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that; There are **two** Fife wide procedures made obsolete at the meeting. **Fife Wide Procedure** **FWP-EC-01 - NHS Fife Wide Procedure for Ear Care including Examination, Irrigation (30/06/2024)** Mr David Walker Clinical Director advised that ear irrigation was not happening now in our acute hospital. Community Treatment and Care Services are taking some of the services away from GPs as part of the Primary Care Improvement Plan and offer that service to their population. A local Standard Operating Procedure will now be written with support from the Group. **FWP-BBMHB-01 Fife Wide Procedure for Babies Born to Mothers with Hepatitis B Infection and/or Babies Born into a household where a member (other than the mother) is known to be infected with Hepatitis B (01/04/2023)** Dr Helen Brotherton, Consultant Paediatrician / Neonatologist using national guidelines is adapting a document outlining local referral pathways, which will now be sufficient. The Group were given assurance that they have a 100% compliance rate for all clinical policies and procedures for NHS Fife.	
4.5	NHS Fife Activity Tracker	
	EM shared the following with the group: **One** new Consultation • Draft guideline consultation Asthma: diagnosis, monitoring and chronic asthma management issued 18 June 2024 **New** standard issued • Draft Pregnancy Screening Standards: Chromosomal and health conditions issued 9 July 2024 FF asked if Pharmacy Team generic mailbox could be included the circulation of any	

	future consultations.	
4.6	SBAR NHS Fife Partnership Review of Children and Young People's Deaths Annual Report	
	CF presented in JK's absence, informing the group; The report outlines the work of Child Death Oversight Panel (CDOP) over the fiscal year, detailing the process for managing reviews of child deaths and the governance and reporting structures. CF pointed out the report is now for the fiscal year so 15 months rather than 12 to bring us in line with the Scottish National Hub reporting. Along with the overview of the work of the group, the report presents the data collected from the 20 deaths that occurred in the reported period 1st January 2023 to 31st March 2024 on every Fife child who died (the deaths may have occurred in a different location, but their permanent address is within Fife). The report considers information from the 20 deaths reported in the 15 months, however a more detailed analysis of fully completed reviews will be available in next year's report due to delays in completing review that is multifactored. Learning from reviews section focuses on completed death reviews from 2022. AL wondered if more detail could be added to the body of the report. Essentially this spoke about process however she would like to see what is being done with the learning. CMcK pointed out that his was a multiagency report and the numbers were very small which means specifics must be kept to a minimum. There perhaps should be a 'side' document only for health learning. He also wondered if we should have Public Health within the review group. GC responded that this report was to give assurance that we had the processes in place and systems for learning. GC felt that we do need to maximise an opportunity locally with a multiagency learning event which could be discussed at the next Review of Children & Young Person Governance Meeting, on 22nd August 2024. She also wished to commend the group on the work that has evolved over the last couple of years. It is positive to see the effect of the multiagency working and the opportunity for learning to support the approach. GC also wished to note thanks to Lorna Watson, Consultant in Public Health Medicine, who has chaired the Governance Group, her last day is Thursday. CMcK asked around the membership of the Governance Group within the report. CF explained that the report was from the Child Death Oversight Panel, which is the operational group. There could be a section added in to include the work of the Governance Group. There was discussion around what some of the group members would like to see within the report, especially around learning. CMcK concluded that although he was content the report progress to CGC, there were considerations for next years report including governance structure and learning.	
4.6.1	NHS Fife Partnership Review of Children and Young People's Deaths Annual Report	
	This report was noted by the Group.	
4.7	SBAR NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as	

	of August 2024	
	SAS spoke to the paper highlighting; • This paper provides the Clinical Governance Oversight Group (CGOG) with details of the corporate risks currently aligned to the Clinical Governance Committee (CGC), prior to reporting on the risks to the Committee on 6 September 2024. • It also provides updates on the current risks and in particular feedback and recommendations from the discussions at the Risk and Opportunities Group regarding the Optimal Clinical Outcomes Risk. • Since the last report to this Group on 18 June 2024, five risks are currently aligned to the CGC (the risk level breakdown is - 3 High and 2 Moderate) and no new risks have been identified. • From the Optimal Clinical Outcomes discussion at the Risk and Opportunities Group, the consensus of the group and the recommendation to EDG would be to close the risk in its current format and consider development of a new risk. An in-depth discussion followed around the Optimal Clinical Outcomes Risk. The Group was generally supportive of a re-write - re-frame of the risk where the root causes have evolved. CMcK concluded in asking the Group to send their thoughts to SAS.	ALL
4.7.1	Appendix 1 NHS Fife Corporate Risks aligned to the CGC as at end of July	
	This was noted by the Group.	
4.8	SBAR NHS Fife Controlled Drugs Accountable Officer Annual Report 2023-24	
	FF advised the Group this report was to provide assurance of the role of Controlled Drugs Accountable Officer Annual (CDAO) to the Clinical Governance Committee (CGC)	
4.8.1	NHS Fife Controlled Drugs Accountable Officer Annual Report 2023-24	
	FF highlighted the following points from the report with the Group; • A programme of Controlled Drug Assurance Assessments ensures that every ward/department holding controlled drugs (CDs) in NHS Fife receives a six-monthly pharmacy visit, to assess compliance with legal and best practice requirements. It should be noted that processes for seeking assurance regarding other requirements (destruction, prescribing, reporting and learning, and the operation of the CD Local Intelligence Network) are covered separately in this report. • Since April 2023, a dashboard was developed to enable monitoring of ordering of CDs and those deemed “attractive” and at risk of diversion, across all wards and clinical areas. The dashboard is reviewed by senior nursing, medical and pharmacy teams, within each ward/ clinical area every month, as an early warning system, to identify trends, themes and any issues in relation to ordering of these medicines. The Pharmacy and Medicines Directorate has set a Key Performance Indicator of 100% for these monthly reviews, which has been achieved consistently since January 2024. • Fife was a recognised outlier from National Therapeutic Indicators (NTIs) in opioids and gabapentinoids and had a higher than Scottish average involvement of such medicines implicated in drug related deaths. This led to the establishment of the High-Risk Pain Medicines (HRPM) programme which aimed to develop a whole system approach to alternative ways of managing pain, provide assurance on the safe and effective prescribing of these	

	medicines and to create a culture change in prescribing to optimise patient benefit and minimise risk of harm to patients.
	• Fife demonstrates an open culture that encourages reporting of CD related incidents. This is demonstrated by a good reporting rate of incidents, with a low proportion of harm. The Managed Service report CD incidents via DATIX and independent contractors report CD incidents via the CDAO Incident Reporting form. In 2023-24, Community Pharmacists were the only independent contractors who reported incidents. Reporting by other independent contractors will be scoped through self- assessment audits.
	• 10 (2.5%) incidents were recorded as major outcome in terms of harm
	  o 8 of these incidents were due to "missing stock" which cannot be accounted for. These incidents are investigated following procedures, and a SAER undertaken.
	  o 2 Incidents related to suspected theft involving staff members.
	
	FF also highlighted that here has been a significant increase in the number of incidents reported by community pharmacies. This reflects an increased awareness of the importance of reporting and an improvement in how incidents are reported as well as a change in ownership of the pharmacies.	

5	**ADVERSE EVENTS UPDATE**	
5.1	NHS Fife Adverse Events KPI's	
	This was noted by the Group and no comments made.	
5.2	NHS Fife Adverse Events Incidents Flashcard - July 2024	
	This was noted by the Group and no comments made.	
5.3	NHS Fife Adverse Events Themes & Trends - August 2024	
	CF shared with the group that she had an assigned action by CGC to identify if there are any recurring themes for those categorised as 'other clinical events' for the major or extreme category. Overwhelmingly the highest reported category, accounting for 18 of the 68 SAER's commissioned in 2023, is 'other clinical events'. CGC members were keen to understand what lay beneath this overarching category and sought assurance that there was no emerging theme from this category that is currently indefinable. CF provided assurance to the group that a detailed analysis had been carried out on 12 months of data from the 10 subcategories that make up the other clinical event category. Using data over time methodology and run charts there was no identified non-random variation or astronomical points in any of the data from the subcategories that would indicate a concern. CF asked the group for some steer around potential opportunities to improve the visibility of theses event types. CF outlined 3 options, the category remains the same and it's included within the 'Themes & Trends' reporting, the category to be redefined / redescribed by renaming or should we consider splitting the category and recategorize by type specific categories i.e. Unexpected Deaths sits under the other clinical events category and had 20 events reported in 2023. CMcK confirmed he would advocate that 'Unexpected Death' category be removed and replaced with something different. He would welcome a proposal at the next	 **CF**

	meeting.	
5.4	NHS Fife Adverse Events Process Update	
	CF gave an overview of where we are with the Process Update. The trigger list has been redefined following engagement with key individuals from across the organisation at a number of workshops. There is still work to be done to define what the governance process will be for the categories of Falls, Tissue Viability and Staphylococcus Aureus Bacteraemia (SAB's), which previously, as a blanket approach, fell into the category of major and extreme. These will now be moderate harm unless the actual harm to the patient fits criteria for major/extreme. CMcK noted that there is an upward trend of SAB's as identified in the IPQR, however, as they are now classed as moderate, they no longer trigger the email notification of event occurrence to seniors across the organisation. This detail will be held locally but he wondered about their visibility. NB added that as SAB's are within the monthly report from Infection Prevention Control if there was an increase this would trigger an escalation.	
5.5	SBAR NHS Fife Adverse Events Staff Support Pathway	
	CF highlighted the purpose of brining the paper to raise awareness of the impact adverse events can have on NHS Fife staff and gain senior organisational insight and strategic steer to overcome the emergent challenges and support next steps for development in terms of, coordination, resourcing and delivery of the pathway. CF provided some background to the origins of this piece of improvement work and detailed the journey of the SLWG in understanding the issue and best practice, engaging staff and developing a pathway with associated education and resources which formalises and provides structure to staff support following an adverse event. CF discussed some of the challenges around having enough staff trained to deliver cold brief sessions which is a part of the support pathway and was delighted to inform the group that Fife Health Charities has funded a cohort of 12 individuals to complete this necessary training commencing in Autumn this year. Having the appropriately trained workforce to deliver the pathway as a whole only represents a proportion of the resource required to effectively delivery the pathway. The successful delivery of the pathway is reliant on a top-down approach that considers that value is added by recognising the needs of staff following an adverse event and responding by having process in place that is timely and meets individual's needs. The greatest resource burden is staff time, to facilitate debriefs and speak to staff on a one-to-one basis where requested. In particular, cold debrief session and peer support sessions are predominantly provided on good will. There is a requirement for a culture of staff support being the norm after adverse events and not by exception. This will require an approach where senior leaders and managers are enabling individuals delivering support, the time to do this effectively. CMcK stated that this was very important work and if there are barriers, we have to find a way of making it happen. IM added that he agreed this was of high importance, he had noticed over the last 6 months or so that the expectations of this process are higher now than ever before. Junior doctors rotating from other larger boards are used to larger set ups and expect a debrief after an adverse event. He feels the need to find resource for this is paramount.	

	GC concluded that this is an investment for us, for our organisation and for our staff. She highlighted the funding for this is coming through the 'charities foundation'. What we need is leadership enablement to make this the norm of how we support staff instead of the exception. It would be really valuable for CF to get feedback from the colleagues in this Group. SF added that Staff Wellbeing in general was one of the areas they were keen to develop over the next year within Medical Education. How do we support our training staff in situations which may otherwise pose a threat to their wellbeing. He will connect with CF to further discuss this work. CF will circulate the pathway documents along with a questionnaire to senior leaders across the organisation to identify barriers and enablers for the progression of this work.	**CF**
6	**STRATEGY / PLANNING**	
6.1	NHS Fife Deteriorating Patient Report Quarter 1 April - June 2024	
	GS summarised from Q1 April – June 2024 report highlighting; The number of 2222 calls; 98 - VHK 11 - QMH 24 - all other community hospitals. Number of non-cardiac arrest/non-peri arrest calls (e.g. falls, major haemorrhage) 66 - VHK 8 - QMH 15 - All Other Community Hospitals The mortality rate for actual cardiac arrest of which there were 16 was 38%. There had been an improvement in structured response in VHK to 60%. GS also shared with the group that there is a Deteriorating Patient Workshop tomorrow, 23rd August 2024, where the aim is to use the expertise across the organisation to formulate a workplan for the next 12 months. CMcK acknowledged the excellent report.	
6.2	NHS Fife Deteriorating Patient Flash Report Cardiac Arrests January to June 2024	
	GS explained that one of the asks of the organisation was to share outcomes from cardiac arrest with staff. This is the first report prepared that will be widely shared with wards and departments across Fife The report highlights good practice noted following cardiac arrest reviews ❖ Prompt/timely recognition of deterioration ❖ Clear evidence of senior review ❖ Observations completed on time ❖ SR Sticker used correctly and hourly observations completed as appropriate ❖ Clearly noted plan and ceiling of care documented in notes	

	The report also highlights areas of improvement identified from cardiac arrest reviews: ❖ Use of Structured Response (SR) sticker when a patient has an Early Warning Score (EWS) of 3 or more ❖ Admission document for escalation status has not been completed fully ❖ Earlier decision regarding DNACPR ❖ Better fluid balance chart documentation ❖ Observations not obtained after 60 minutes when patient FEWS 4	
7	**LINKED COMMITTEE MINUTES**	
7.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, unconfirmed - 24th June 2024 **(EM)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.2	NHS Fife Acute Services Division Clinical Governance Committee, unconfirmed - 24th July 2024 **(IM)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.3	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 12thJuly 2024 **(LB)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.4	NHS Fife Point of Care Testing Committee - 5th June 2024 **(EM)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.5	NHS Fife Resuscitation Committee - 11th June 2024 **(NR)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.6	NHS Fife Deteriorating Patient Group - unconfirmed, 5th June 2024 **(IM)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.7	NHS Fife Health & Social Care Partnership Falls Oversight Group - 25th March & 27th May 2024 **(LB)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.8	NHS Fife Organ and Tissue Donation Committee - 27th June 2024 **(NR)**	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
7.9	NHS Fife Food, Fluid and Nutritional Care Steering Group - 29th May 2024 **(NB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
8	**ITEMS TO NOTE / INFORMATION**	
8.1	NHS Fife Clinical Governance Oversight Group Assurance Summary 18th June 2024	

	(GC)	
	This was noted by the Group.	
8.2	NHS Fife Deteriorating Patient June 2024 Highlight Report **(GS)**	
	This was noted by the Group.	
8.3	NHS Fife Deteriorating Patient July 2024 Highlight Report **(GS)**	
	This was noted by the Group.	
8.4	NHS Fife Clinical Governance Oversight Group Annual Workplan 2024/25 **(GC)**	
	This was noted by the Group.	
8.5	NHS Fife Clinical Effectiveness Register **(EM)**	
	This was noted by the Group.	
8.5.1	NHS Fife Clinical Effectiveness Projects Flash Report January - June 2024 **(EM)**	
	This was noted by the Group.	
11	**ISSUES TO BE ESCALATED**	
	Insufficient Trauma Theatre Capacity NHS Fife is a negative outlier (-3SD) for time to theatre within 36 hours for hip fracture patients. NHS Fife, consistently > 5 years, has not attained the key performance indicator 6: Time to theatre < 36 hours. There are local actions in place to deal with Insufficient Trauma Theatre Capacity, an expedited action plan is underway ahead of a meeting with the external review team, with a plan to bring it to CGC in November.	
12	**ANY OTHER BUSINESS**	
	Date of Next Meeting 22nd October 2024 10.00 via Microsoft Teams	

AREA DRUG & THERAPEUTICS COMMITTEE

(Meeting on 19 June 2024)

No issues were raised for escalation to the Clinical Governance Committee.

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 19 JUNE 2024 AT 2.00PM VIA MICROSOFT TEAMS

Present: Ms Fiona Forrest (Chair)
Dr Helen Hellewell
Ms Alice Mathew
Dr Sally McCormack
Ms Rose Robertson
Ms Amanda Wong

In attendance: Mr Ryan Headspeath (agenda items 2, 8.2, 8.3 and 8.4)
Ms Anne Wilson (agenda items 2, 8.5 and 8.6)
Mr Duncan Wilson (agenda item 2)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Ms Forrest welcomed everyone to the June meeting of the ADTC.

Apologies for absence were noted for Lynn Barker; Dr Ian Fairbairn; Dr Claudia Grimmer; Mairi McKinley; Dr John Morrice; Nicola Robertson; Olivia Robertson. It was confirmed that the meeting was quorate.

2 PRESENTATION BY SCOTTISH MEDICINES CONSORTIUM

Dr Scott Muir, SMC Chair and Dr Yvonne Semple, SMC Chief Pharmaceutical Adviser were welcomed to the meeting and presented an update on the background to the SMC, current workload and processes, achievements and plans for continuing to strengthen relationships with Board ADTCs going forward.

3 MINUTES OF PREVIOUS MEETING ON 17 APRIL 2024

The minutes of the meeting held on 17 April 2024 were accepted as a true record.

4 ACTION POINT LOG

It was noted that all action log items scheduled for update have been included on the agenda.

Prescribing in Renal Impairment (DOACS)
Refinement of the Action Plan to be taken forward through the Medicines Safety and Policy Group and brought back to the ADTC thereafter for update and assurance.

Submissions to MSDTC for non-Formulary items – reminder of governance route
Ms Forrest to arrange a meeting with the MSDTC secretariat to discuss. **FF**

5 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

6 DECLARATION OF INTERESTS

There were no declarations of interests.

7 ADTC SUB-GROUP UPDATE REPORTS

7.1 East Region Formulary Committee

Ms Mathew introduced the update report from the East Region Formulary Committee (ERFC) and highlighted key points.

The review of the Paediatric Skin ERF Chapter has been completed. Chapter Expert Working Groups are being established to progress review of the CNS and Nutrition and Blood Paediatric Chapters.

The ADTC noted that a new pre-ERFC external review process to consider implications of Formulary Applications within patient pathways and provide advice to the ERFC is currently being trialled. Further communications along with findings from the trial will be shared in due course.

The ADTC noted that Dr David Griffith has advised of his intention to stand down from his role as ERFC co-chair; Dr Griffith will continue to serve as a member on the ERFC. Ms Mathew to liaise with Dr McCormack and Dr Hellewell to identify a new Fife Co-Chair going forward. It was also noted that NHS Fife is continuing to provide additional support for the ERFC Secretary role pending recruitment of an NHS Borders Formulary Pharmacist. **AM/HH/ SMcC**

The ADTC noted the comprehensive update from the East Region Formulary Committee and good work ongoing.

7.2 MSDTC

Ms Mathew introduced the update report on behalf of the MSDTC and highlighted key points.

The report detailed the guidelines that have been approved, provisionally approved and rejected since the last update to the ADTC. The MSDTC Terms of Reference is scheduled for review as part of the workplan for the next six months.

A general increase in guidelines submitted to the MSDTC for review was highlighted. The need for clarity with regard to the inclusion/exclusion criteria

for submission of guidelines through the MSDTC review process along with guidance or a flow chart outlining the governance process for ratification of guidelines prior to submission to the MSDTC was highlighted. The ADTC noted that the MSDTC has good clinical representation and provides a robust critique process for guidelines however clarity around the governance pathway would help to ensure that there is no duplication of business between the various governance groups.

The ADTC also noted proposals for establishment of a pre-MSDTC meeting to review and approve certain items in order to streamline incoming work for the MSDTC.

Ms Forrest and Dr McCormack to discuss issues highlighted along with review of the MSDTC Terms of Reference and bring to the ADTC for ratification in due course. **FF/ SMcC**

The ADTC noted the update on behalf of the MSDTC and supported the proposals for taking forward the issues highlighted.

7.3 PGD Group

Ms Mathew introduced the update report on behalf of the Patient Group Direction (PGD) Group and highlighted key points.

The key achievements since the last update report were highlighted along with the workplan for next six months.

There are currently 205 PGDs in use within NHS Fife, with over 50 due for review in 2024. The workplan for the next six months includes review of current PGDs according to the Standard Operating Procedure interval along with the development of any new PGDs and withdrawal of any that are no longer required.

The ADTC noted the workplan for the next six months and the plan for prioritisation of PGD review work. The ADTC noted that the risk management tool continues to be monitored monthly and the relative risk remains stable.

The ADTC noted the update report on behalf of the PGD Group and supported the plan in place for prioritisation of PDG review work going forward.

7.4 Medicines Safety and Policy Group

Dr Hellewell introduced the update report on behalf of the Medicines Safety and Policy Group and highlighted key points.

The ADTC noted the key achievements including establishment of the Medicines Safety Programme workstream subgroups (Anticoagulants, Diabetes, High Risk Pain Medicines, Lithium and Valproate), establishment of the Medicines Assurance and Audit Programme (MAAP) short-life working

group. The ADTC also noted the impact of establishment of the weekly multidisciplinary Medicines Safety Drumbeat meetings in identifying any common themes and learning required and sharing of information with staff through the weekly Medicines Safety Bulletin.

The ADTC noted the details of the workplan for the next six months.

The ADTC noted the update on behalf of the Medicines Safety and Policy Group and the positive progress made.

8 SBARs

8.1 Medicines Shortages Protocol SBAR

Ms Mathew introduced the Medicines Shortages Protocol SBAR and highlighted the key proposed changes to the Policy for Managing Medicines Shortages in Primary and Secondary Care.

Although the current Policy continues to be in line with Best Practice Standards, due to the continued increase in medicines shortages, it was deemed that amendments to the Policy were required to ensure that there is a cohesive robust process and communication plan in place across the organisation for the management of medicines shortages.

The Policy outlines the roles and responsibilities of all healthcare professionals and includes a number of appendices detailing the communication process to ensure that there is a single system approach to the management of medicines shortages.

The ADTC noted that clarification of the communication process following resolution of medicines shortages was required to ensure continued use of the most clinical and cost effective product. Ms Mathew and Mr Notman to discuss off-line and consider where any additional information required to the added to the sit-rep as part of the risk assessment process. **AM/FN**

The ADTC noted changes required to the contacts for dissemination to specialties in the Acute Service and Health and Social Care Partnership. The location for hosting information relating to shortages on Blink also requires clarification. **AM/FN**

Subject to the agreed amendments the ADTC approved the updated Policy for Managing Medicines Shortages in Primary and Secondary Care. To be brought back to the ADTC in June 2025 to consider whether any further review is required.

8.2 Lithium Shared Care Agreement

Mr Headspeath introduced the Lithium Shared Care Agreement and highlighted key areas.

It was noted that an updated version providing clarification around contact

details and additional information to support General Practitioners with potential queries was circulated in advance in the meeting. The Shared Care Agreement has been reviewed by the Shared Care Group and amendments have been made by the Mental Health Team in response to comments received.

The ADTC noted the proposed contact points for routine enquiries, urgent advice and advice outwith regular hours and suggested that contact details for the individual patient's Consultant/psychiatrist should also be highlighted in the treatment plan. The ADTC also noted that responsibility for the physical health/ blood monitoring and actioning results required clarification. Mr Headspeath to feed back comments to the Mental Health Team and amend accordingly. **RH**

Subject to clarification of monitoring arrangements and agreed amendments the ADTC supported the Lithium Shared Care Agreement.

8.3 Methotrexate Shared Care Agreement

Mr Headspeath updated the ADTC on progress with development of the multi-specialty Methotrexate Shared Care Agreement.

It was noted that the Shared Care Agreement is in draft format and aspects of the monitoring guidance is still to be finalised. An update on progress with review of the Shared Care Agreement has also been discussed at the GP Sub-Committee and there was positive feedback and support for the multi-specialty Methotrexate Shared Care Agreement continuing in existing patients. The final version to be taken to the GP Sub-Committee in August.

The ADTC noted progress with development of the multi-specialty Methotrexate Shared Care Agreement. The updated version to be circulated to ADTC for virtual approval ahead of the next GP Sub-Committee and brought to the August ADTC for final ratification. **RH**

8.4 Hydroxychloroquine Shared Care Agreement

Mr Headspeath introduced the final draft Hydroxychloroquine Shared Care Agreement and updated the ADTC on the background to this.

The ADTC noted that the existing Hydroxychloroquine Shared Care Agreement currently in use by Rheumatology has been updated to include Dermatological indications. The Shared Care Agreement provides clarification of the recommended dose and confirmation of Secondary Care responsibility for initiation and review of patients to assess response prior to implementation of shared care. There are no routine blood monitoring requirements with Hydroxychloroquine.

The ADTC approved the updated Hydroxychloroquine Shared Care Agreement and thanked Mr Headspeath for his work in taking this forward.

8.5 Review of Hospital at Home PGDs SBAR

Ms Wilson introduced the SBAR Review of Hospital at Home PGDs and briefed the ADTC on the background to this.

The ADTC noted the work undertaken to review and rationalise the number of PGDs in use across the three Hospital at Home sites. The SBAR outlines the PGDs still in use and those that have been withdrawn as they are no longer deemed necessary.

The ADTC noted the proposal that the remaining streamlined Hospital at Home PGDs remain in place at present and the rationale for this. It was agreed that there was a need for these to be reviewed regularly as the staff within the Hospital at Home service change/ become prescribers and upon implementation of electronic prescribing.

The ADTC thanked Ms Wilson for the work undertaken to review and rationalise the Hospital at Home PGDs and supported the recommendations for review going forward as set out in the SBAR. A brief update report to be brought to the ADTC in June 2025. **AW**

8.6 Review of Just in Case Standard Operating Procedure SBAR

Ms Wilson introduced the SBAR Review of Just in Case Standard Operating Procedure and briefed the ADTC on the background to this.

The ADTC was asked to review the SBAR, Standard Operating Procedure and Implementation Plan and agree progress to the next stage of the consultation process prior to launch.

The ADTC noted the proposed changes following wide consultation with all stakeholders. The ADTC supported the recommendations outlined in the SBAR and agreed that the proposed changes should be progressed to relevant governance groups (i.e. Pharmacy SLT, Clinical Governance Oversight Group, PPQMAG, QMAG and HSCP SLT) for consultation/assurance prior to wider communication and launch. Ms Forrest and Ms Wilson to discuss timelines for each of the groups off-line. **FF/AW**

9 Risks Due for Review in Datix

Deferred to August ADTC meeting.

10 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

10.1 Clinical consensus - Guidance criteria for the prioritisation of use of GLP-1 RAs and GLP-1/GIP RAs in the treatment of obesity

The ADTC noted the update on the work undertaken by the short life working group which was established to look at the potential impact of introduction of GLP-1's in weight management. NHS Fife's position to be progressed through the ADTC and other relevant governance groups, prior to submission to East Region Formulary.

11 EFFECTIVE PRESCRIBING

11.1 NCMAG Quarterly Update

The ADTC noted the report "Implementation of NCMAG Advice 2023".

12 HEPMA Update

Deferred to the August ADTC meeting.

13 PACS/SMC Non Submissions

13.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

14 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee.

15 ANY OTHER COMPETENT BUSINESS

There was no other competent business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group** - next meeting 9 July 2024.

b **Minutes of Heart Disease MCN Prescribing Sub-Group 18 April 2024.** For information.

c **Minutes of Respiratory MCN Prescribing Sub-Group 30 April 2024**. For information.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 21 August 2024 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 7 August.

QUALITY & COMMUNITIES COMMITTEE MEETING (Meeting on 5 July 2024)
No issues were raised for escalation to the Clinical Governance Committee.

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 5TH JULY 2024, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Margaret Kennedy Paul Dundas, Independent Sector Lead (PD) Morna Fleming, Carer's Representative (MF) Kenny Murphy, Third Sector Representative (KM) Colin Grieve, Non-Executive Board Member (CG) Alistair Grant, Non-Executive Board Member (AG)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Fiona McKay, Head of Strategic Planning, Performance and Commissioning (FMcK) Jennifer Rezendes, Principal Social Work Officer (JR) Jillian Torrens, Head of Complex and Critical Care (JT) Vanessa Salmond, Head of Corporate Services (VS) Avril Sweeney, Risk Compliance Manager (AS) Lesley Gauld, Strategic Planning Team Manager (LG)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Sam Steele Councillor Rosemary Liewald Councillor Lynn Mowatt Amanda Wong, Director of Allied Health Professionals (AW) Ian Dall, Service User Rep, Chair of the PEN (ID) Nicky Connor, Director of Health & Social Care (NC) Ben Hannan, Executive Director - Pharmacy and Medicines (BH) Lynn Barker, Director of Nursing (LB) Lynne Garvey, Head of Community Care Services (LG) Roy Lawrence, Principal Lead for Organisational Development & Culture (RLaw) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG)

Unconfirmed

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** SB welcomed everyone to the 05 July HSCP Quality & Communities Committee meeting.	
2	**ACTIVE OR EMERGING ISSUES**	
	No emerging issues were reported.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 10 MAY 2024** The previous minutes from the Q&CC meeting on **10 May 2024** were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **10 May 2024** was reviewed. VS advised a member of the Community Care Services will be invited to the next IJB Development Session. An annual update relating to AHP Professional Assurance will come back to Committee in Jan '25. LG has committed to providing 6-monthly updates re the Community Care Rehab model. This is included in the Q&CC Workplan. The Action Log was approved as accurate and the updates provided were noted.	
7	**GOVERNANCE & OUTCOMES**	
7.1	**Quality Matters Assurance** This report was brought to Committee by Helen Hellewell on behalf of Lynn Barker for Assurance**.** HH introduced the report which comes from QMAG which Lynn Barker Chairs. She highlighted the good practice which is emerging from the Mental Health Commission visits. She stated the meeting had to be curtailed as an emergency meeting had been called for at the same time. All outstanding items were carried forward to the next QMAG meeting, however, HH gave assurance there are no concerns	

Unconfirmed

	regarding governance for this having taken place. HH invited questions. SB queried the reference to MAPPA within the minutes of the QMAG meeting. She was pleased to read the positive reviews relating to the MWC visits. HH advised MAPPA is to come through this Committee and understood this was on the Q&CC Workplan. HH suggested it may be useful to meet offline regarding MAPPA. SB stated she would meet with J Rezendes and L Barker outwith the meeting. FMcK advised JR will be joining the meeting, she was experiencing computer issues. FMcK added she has discussed MAPPA with Dougie Dunlop and there is to be a review carried out by DD and his Team. The report will come to a future meeting of Q&CC, and will also include ADP, along with other areas. Currently, this is a work in progress. HH advised, there has been an effort to reduce the length of the QMA report and asked for feedback to be forwarded to herself or LB. MF felt the report was easier to read and follow and gave thanks for the improvement. HH suggested MF be involved in a glossary which is to be created. SB commented on the increase in incidents and queried if there was an explanation. HH advised, an increase in incidents is not always a negative, it can mean Datix is being used more effectively to record incidents. She was happy to pick up a conversation off-line to explain in further detail or perhaps Committee would prefer a deeper dive into specific areas? SB was happy to discuss off-line. SB stated the Committee took Assurance from the report.	**SB** **SB / HH / LB**
7.2	**Quality and Communities Committee Terms of Reference** HH introduced the Q&CC Terms of Reference which was brought for discussion and acceptance. She stated the majority of the changes were accepted at the previous meeting, however, there has been a request from Internal Audit for the reporting arrangements to be clarified around the role of NHS Fife Governance and the Integration Scheme Arrangements. She highlighted the diagram which was included within the ToR. A Chair's Report along with the ToR will go the next meeting of the IJB. CG queried the diagram showing the routes of information flow. He asked why NHS Fife sits with QMAG, before going to SLT, with no route back into SLT. This was discussed in some detail and HH agreed, clarification is required.	**HH / VS**

Unconfirmed

	FMcK felt there was something missing as SLT must be sighted on all matters, and this should be reflected in the diagram. KM agreed the diagram did not quite fit the practicalities of reporting arrangements. He referred to text on page 23, and felt some of the wording was not clear and he would like this to be given further consideration. VS advised, some of the specific wording was in response to points raised by Internal Audit, however, agreed should be revisited. She referred to Child and Adult Protection issues reporting arrangements should be reflected in ToR as a whole system arrangement. HH proposed the mentioned points are considered, and worked through with Internal Audit. VS offered to circulate a refreshed ToR to Members by email for ratification, rather than delaying a further two months until the August meeting. This was agreed.	**VS**
7. 3	**Deep Dive Risk Review for Contractual/Market Capacity Risk** This report is brought to Committee by Fiona McKay and comes for Discussion and Assurance. FMcK introduced A Sweeney, Risk Compliance Manager, who presented the Paper. AS stated, as part of the IJB Risk Management Policy and Strategy, a Risk Reporting Framework has been agreed. As part of the Framework, each Risk on the IJB Strategic Risk Register is assigned to the Q&CC or the Finance, Performance & Scrutiny Committee. She advised, this specific Risk is assigned to both Committees. The Deep Dive Risk Review is shown in Appendix 1 detailing the Risk description and the Risk scoring. The review also highlights the internal and external factors which may impact on the Risk, it provides assurances, performance measures, benefits and linked Risks. A performance summary is shown at the end of the Deep Dive Risk Review. AS outlined the question set out in Appendix 2 which is to aid Committee Members in their scrutiny of the Risk. The key mitigations were described. The collaboration of Care Home and Care @ Home, and new systems such as Pin Point have been key to the work. AS stated, the Care @ Home collaborative report is now used as an exemplar by Scottish Government. Mitigations have been identified through the Strategic Planning Group. A new performance framework is providing additional assurances and control measures and information on performance and benefits is being sought from a quality and quantity perspective, which AS gave detail of. Agreed actions are ongoing, it was acknowledged there are factors out with the Partnership's control, however, these are being monitored. PD thanked AS for the report. He felt a good understanding of oversight of the whole system is established and there is	

Unconfirmed

	mechanism in place to be aware of Risks and to mitigate them quickly. KM felt the report was comprehensive. He felt it was difficult to identify any other mitigations which could be put in place. He queried the amber status given to the Risk, however, it was agreed with the number of external factors, this was appropriate. FMcK spoke of close working with the Partners around finances. MF referred to page 32 of the report, increased demand for services and unmet need. She felt alternative wording could be used to describe the level of Risk impacting Carers more closely, which she felt should be acknowledged. AS agreed to revisit the wording on page 32. The Committee took Assurance from the Deep Dive Risk Review.	**AS**
8	**STRATEGIC PLANNING & DELIVERY**	
8.1	**Community Led Support Services Progress Report 23/24** FMcK was very pleased to bring the Community Led Support Report as there has been a tremendous amount of work taking place. The report was brought to Committee for Assurance. She described the many Services and work with GPs re direct referrals, also work taking place across Localities and with Acute Services through The Wells. She advised from Page 50 onwards within the report, significant work is outlined which has been taken forward. She referred to figures which are coming through, particularly referrals from The Wells. She added, The Wells only operates 24hrs per week. FMcK referred to staff losses, which caused a temporary loss in referrals, however, these staff have now been replaced. She spoke of work taking place with Fife Council's 'No Wrong Door' Programme and funding which has been received for The Wells from Area Committees and from the Homelessness Housing Project, providing additional support. Questions were invited. Cllr Kennedy was very pleased to see the increase in the number of men engaging with The Wells. She commented on the Link 24/25 CARF, as it is well known financial issues can be a factor in poor mental health and wellbeing. She was concerned issues around staffing, funding and sustainability could be a threat to continuity of the less bureaucratic services. She felt this was a huge concern moving forward. FMcK agreed there is a challenge securing funding, however, her and the Team's commitment to ensuring these services continue is steadfast. She spoke of an impending visit from the Chief Executive of Fife Council to The Wells	

Unconfirmed

MF was very complimentary of the simplicity of the report and felt it would be readily understood by the public. She asked why there were no stats for The Wells and referred to the Case Study of Steven who was diagnosed with Cancer. He asked why the support available was not signposted to Steven at the time of diagnosis, she asked this is addressed.

FMcK stated individuals are given information at the time, however, the person is not always ready to accept the support. She felt the wording in the report gives the impression the information was not readily available, the wording will be reviewed. FMcK told of the process which is followed from Acute Services, which is a Government approved MacMillan process.

FMcK advised the recording system used for The Wells is a WIP to find a suitable system.

PD commended the report which showcases the range, quality and diversity of the work taking place by Jacqueline Stringer and her Team. He spoke of further services which are coming forward through Community Led Support.

The Committee took Assurance from the report.

9 LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS

9.1 Fife ADP Annual Report and Annual Survey 2023-2024

FMcK introduced the report which was brought to Committee for Discussion and Decision. She advised Elizabeth Butters, who normally presents the report is currently on leave. Nicky Connor, who was Chair of the ADP, has been heavily involved in the work which has taken place.

FMcK ran through the main highlights from the report. She stated all of the MAT standards for Fife have been graded as green, which is a significant achievement for the Team.

S Braiden thanked F McKay for what was an excellent report.
M Fleming queried page 107, asking why drug related deaths are still so high. She commented, not receiving official figures for 2023 until July 2024 seems very late and having to rely on figures from Police Scotland was not helpful as the figures were incomplete. She referred to Page 128 and asked why Fife suffers from such a high level of Benzodiazepine hospital admissions. Also, page 134, she queried why a very increased level of alcohol Brief Intervention was a positive.

HH wished to comment on the alcohol intervention and explained this relates to having an intervention before alcohol misuse becomes ingrained for a person. She stressed the benefits of intervening at an

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earlier stage. She suggested this could be made clearer in the report. She described a high level of work which goes into investigating Drug Deaths in Fife and there is work coming forward re Benzodiazepine use.

FMcK stated drug deaths in Fife have been lower than the Scottish average, however, one death is too many. She advised due to the young people's deaths, there has been an Oversight Group established to consider messaging to younger people to ensure Fife is getting this right. She advised 'Clued Up' is supporting to ensure the correct messaging is used. She spoke of the work Addiction Services do to support the work. FMcK described working with people with lived experience being vital and HSCP have funded support for family carers. She described several of the supports which are provided.

K Murphy was supportive of EBIs as a positive early intervention and asked if more work is taking place because the workforce is better or because demand is higher and it is a growing problem, or a bit of both? HH spoke of the complexity of the matter with a closer look and monitoring required.

FMcK added the ADP are looking at EBIs. She explained, there is a national target in which Fife are way ahead (green). Currently looking to discover if Fife are doing anything unnecessary which could save finances if stopped.

SB queried the residential treatment facility, she asked if there is involvement with the Third Sector. FMcK advised, Fife HSCP do not commission residential rehab themselves, it goes to FIRST, who commission on Fife's behalf. She explained, FIRST are able to negotiate rates more effectively than HSCP and she described work FIRST do and their involvement with ADP.

SB also asked why drug deaths are so high, and queried if Fentanyl is a growing problem. She felt the ADP have done tremendously well given the national context.

LC has been working on the Young Person's Drug Death Task Force Group which has recently been established. She told of the good work they are doing and preventative work taking place.

JT, Head of Complex & Critical Care, new into post is joining the ADP Committee. She stated, Addiction Services in Fife have a huge caseload - currently over 2200 cases, she spoke of work with partner agencies to bring drug death figures down.

CG acknowledged the positive work which is taking place and the multi-faceted community safety aspects involving HSCP, Community Safety Partnership and Localities.

FMcK agreed, joined up working is critical with partnerships, police, fire, community safety all linking together.

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	SB thanked FMcK for the report which the Committee were happy progress.	
9.2	**Annual Performance Report 2023-2024** The report is brought to Committee by Fiona McKay, she explained all IJB's who have a Strategic Plan are required by Scottish Government to submit an Annual Performance Report by end July each year. This will be measured against all Partnerships within Scotland and feedback will be provided. FMcK stated the report has grown each year and it is to give a flavour of the significant work which is taking place within the Partnership. She referred to demographics, awards received, locality planning, performance linked to National Health & Wellbeing outcomes and Public Health Priorities for Scotland. She stated the report is on a journey with other elements to be added, particularly the Introduction and Best Value. MF gave thanks for the report and felt the reports are becoming easier to read. She queried "why there is a 12-16 week lag in discharge diagnosis coding" and asked if this is likely to reduce. She was concerned to learn why only 27.6% of Unpaid Carers felt supported in their caring role. FMcK responded by advising data must be verified through Scottish Government, resulting in a lag. She felt this could be picked up and perhaps 'informal' data used. Re Unpaid Carers, new reporting has been received with an increase to 30% for 2024, slightly higher than Scottish average, however acknowledged there is still lots of work to be done. Carers forums, sign-posting and other work taking place should help to improve the situation. PD highlighted the good work LGould has included with graphics, charts, QR codes, etc which he felt has made a positive difference, FMcK agreed. KM referred to Appendix 3, National Indicators, he was surprised to see a 5th with no data available. FMcK agreed and explained a position has not been reached where there is a consensus across the country. This will be highlighted when the report is submitted to the Government.	
9.3	**Creating Hope for Fife : Fife's Suicide Prevention Action Plan** LC introduced the report which was brought to Committee for Assurance. She stated, a significant programme of work has been undertaken to deliver the Suicide Prevention Plan for Fife. She gave a background to the report and explained the aim is to reduce the number of suicide deaths through prevention and early	

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	intervention as well as tackling the inequalities which contribute to suicide. LC gave an outline of the Plan and referred to the data within it. She spoke of the multiple stakeholder agencies involved, effective communication, training and education for staff and reducing risk. Governance reporting for the Suicide Prevention Action Plan will come through the Mental Health Strategy moving forward. FMcK advised the HSCP fund support organisations, linking into Mental Health Strategy and Drug & Alcohol Strategy. KM referred to the Summary Paper, sections 6,7,8 and 9. He asked the purpose and stated there should be detail provided. LC agreed to investigate. JT referred to the guidance which differentiates between a drug death and suicide which she offered to share. There was discussion around links between Addiction Services and Mental Health Services. A helpful report from the MWC 'Ending Exclusion" brings the services together to have a more holistic approach. JT will share with Members. SB advised the Committee took Assurance from the report.	**LC** **JT**
9.4	**Children's Services Annual Report 2022/23** The report is brought to Committee by Lisa Cooper for Assurance. LC described how the report shapes delivery of HSCP's Children's Services and how it is constituted. She spoke of the various Services, highlighting areas of success, such as Children and Young People's Occupational Therapy Service, a professional enquiry line has been developed and supported with significant demand and with positive outcomes. Also, the Children and Young People's Community Nursing Service was awarded the 'Children & Midwifery Award' at this year's RCN Scotland Nurse of the Year Awards. CG commented on the lack of accessibility of links within the report. LC will ensure these are updated and can be easily accessed. SB advised the Committee took Assurance from the report.	**LC**
10	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	

Unconfirmed

	10.1 Quality Matters Assurance Group Unconfirmed Minute 17.05.24 10.2 Clinical Governance Committee Unconfirmed Minute 03.05.24 10.3 Fife Alcohol, Drugs and Therapeutics Committee Unconfirmed Minutes 17.04.24 10.4 Strategic Planning Group Unconfirmed Minutes 02.05.24	
11	**ITEMS FOR ESCALATION** No items for escalation.	
12	**AOCB** No other business requested.	
13	**DATE OF NEXT MEETING** **Wednesday 04 September, 1000hrs, MS Teams**	

Unconfirmed

INFECTION PREVENTION AND CONTROL COMMITTEE (Meeting on 7 August 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed
7th August 2024 at 1400 via Teams

Item No	Subject	Actions
1	**Attendees** Janette Keenan, HAI Executive, Director of Nursing (chair) **JK** Claire Connor, Dental Practice Co-Ordinator **CC** Amy Mbuli, Lead IPCN **AMb** Lynsey Delaney, Infection Control Surveillance Audit Midwifed **LD** Midge Rotheram, Support Services Manager **MR** Kirsty Wilson, Consultant - Occupational Health **KW** Catherine Gilvear, Head of Quality, Clinical & Care Governance **CG** Jamie Gunn, Health Protection Nurse Specialist **JG** Sue Blair, Consultant in Occupational Medicine **SB** Keith Morris, Consultant Microbiologist **KM** Suzanne Watson, Senior IPCN Care Homes **SuW** Paul Bishop, Assoc. Director of Estates **PB** Priya Venkatesh, Consultant Microbiologist **PV** Sharon McDonald (Minutes) **SM**	
	Apologies David Griffith, Norma Beveridge, Iain McLeod, Neil McCormick, Aileen Lawrie, Lynn Burnett, William Nixon, Julia Cook, Mirka Barclay, Elizabeth Dunstan	
2	**Minute of Previous Meeting** Minutes of previous meeting were approved.	
3	**Action List** JK to chase IPC access to Morse. JC to discuss with OH pertussis boosters being offered to staff every 5 years. JC to raise with lab managers funding for testing candida auris.	 **JK** **JC** **JC**
4	**Standing Items**	
4.1	**Risk Register** JK presented slides. 20 current risks: 3 – high 15 – moderate 2 – low (it was agreed risk 2748 (w5) can be removed) 1 new risk added – LIMS implementation and configuration with ICNet (2994) AM raised the concerns of documentation for mental health wards in MORSE and the effects of IPC having no access. JK agreed this should be added to the register.	**JK/JC**
4.2	**HAIRT Board Report** LD gave overview of report. Up to end June 2024 • SAB – reduction in year ending totals • CDI – reduction in year ending totals	

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	• Challenges - 4 PVC SABs this year. 1 dialysis line SAB. • 4 x PWID related SABs • ECB – slight increase in HCAI and CAI • Surgical site surveillance – paused **SAB** • Below national average rates for HCAI • Above national average rates for CAI **MRSA & CPE** • NHS Fife down for Q2. Met MRSA, CPE below target. **CDI** • NHS Fife was below the national rate for HCAI and CAI. • Risk rating increased – 67% PPI, 53% antibiotics prior to infection. There was further discussion around picking up GP assessments with medication and how we link in and communicate findings. JK will raise with Fiona Forrest. PV will put together a paper for CG to raise with Helen Hellewell **ECB** Increase in HCAI and CAUTIs. **Targets** SABs met (only mainland Health Board to have reduced target), but not met for CDI or ECB. Awaiting new targets, which have been extended for a further year. **Domestics & Estates Monitoring** Above targets. **Hand Hygiene** No information at present. **Outbreaks** May & June 2024 • 4 GI – 2 confirmed Noro • No flu outbreaks • 7 COVID KM raised that COVID is not a seasonal illness. We need to plan and manage this in terms of previous understood testing regimes, such as point of care. Discussions underway with Infection Prevention team.	**JK** **PV**
4.3	**Care Home Update SW** • Support following Care Inspectorate issues – walkabout and bespoke training. • SIPCS training ongoing. • Link Practitioner training to commence in 10 Care Homes. • Scabies – local and national protocols working groups ongoing. First draft feedback to be implemented. • Working with Dermatology re training with AMPs and GPs. • Routine visits – monthly contact, bi-monthly visits. • Scabies Awareness training has been implemented in CH with very good uptake.	
4.4	**NHSS National Cleaning Services Specification** • Report was discussed. • Increase in results from last year. • Public audits restarted in April 24. • National work with team from SAS to see how audits are done. • Discussed the challenges and impact of the reduction in the working week. • MR and PB to meet separately regarding ward layout and closures.	**MR & PB**
4.5	**Learning Summary** Nothing to report.	
4.6	**National Guidance** AM reported updates: Care Home resources. Transmission based precautions being reviewed Sharps guidance and that a local review of the update is being considered Launch of Chapter 4 around water testing in Scotland – this will be a bigger piece of work For noting – staff confusion around COVID. IPC, HR and OH are working on this.	

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	SB discussed the option of EDG going beyond National Guidance. Requested to be picked up separately by JK and AM.	**JK & AM**
4.7	**Isolation & Risk Assessment** AM – isolation risk assessment in mental health areas are underway. Risks – challenge where areas are on MORSE and this is being requested.	
4.8	**Quality Improvement Programmes** **PWID & UCIG** CG – discussed flash reports and asked for any feedback.	
4.9	**Education** AM reported: Gloves Off – reported Acute Procurement have reported reduction in spend. Link Practitioner Training. 11 staff trained so far at QMH as a test site. Half day study days at VHK and Stratheden are on Blink and will be on Turas shortly. Undergrad Nursing – UoD in August Module with UoStA in September. SCRIBES education. General update provided on the IPC Education Programme	
4.10	**Infection Prevention & Control Audit Programme Update** AM reported: Up to date with audit programme. S&C challenges were discussed.	
4.11	**HAI-SCRIBE** AM highlighted: Equans meetings to get back on track. Education strategy for HAI SCRIBE, refresh link with NHS Assure. Generic HAI-SCRIBE documents in development. KM highlighted the endoscopy at QMH issues. AM has discussed with PB and has a meeting scheduled with all involved as a debrief.	**Action PB**
4.12	**Capital Planning** Nothing to escalate.	
4.13	**Infection Prevention and Control Annual Work Programme Update** AM reported this is now complete.	
5	**New Business**	
5.1	**Incidents/Outbreaks/Triggers** Norovirus – has been seen throughout the years causing closures. COVID – numbers reduced but still causing some closures Legionella Phase 1, VHK – been closed down on the ARHAI system Pseudomonas trigger ICU– ongoing. MSSA in NNU – been closed down on ARHAI system	
5.2	**The IPC Workforce Strategy 2022-24** Refer to document.	
5.3	**ICNET AND LIMS** Still not fully functioning. Remains on the risk register.	
6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**	
6.1	**Infection Prevention & Control Team** Nil to raise.	
6.2	**NHS Fife Decontamination Steering Group** Nil to raise.	
6.3	**NHS Fife Antimicrobial Management Team** Nil to raise.	
6.4	**NHS Fife Water Safety Management Group** Nil to raise.	
6.5	**NHS Fife Ventilation Group** Nil to raise.	
6.6	**NHS Fife HAI Scribe Planning Group** As presented earlier.	
6.7	**Quality Reports**	

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	Nil to raise.	
7	**Any Other Business**	
	AM for noting: Lucky Ewe – farm animals within hospital site. Env. Health to be involved, IPCT not in favour of this move. RTP – concerns raised around staff being unsettled and vulnerable due to all the movements. KW, new Consultant in Occupation Medicine, introduced herself to the group. SB – raised issues of increased prevalence of TB. Currently at around 50 cases. TB clinic unable to take on cases and are being referred back to GPs. Discussion was had around adding vaccination status of staffing and if needed to be on the risk register. SB also asked if it's worth raising screening to original standard (varicella, measles, and pertussis) regarding staff who don't come back for immunisations after being in post. To be discussed further with JK. Health Protection to be added to future agendas.	IPC/OH/JK SMc
8	**Date of Next Meeting**	
	2nd October at 2pm, via Teams.	

Medical Devices Group (Meeting on 12 June 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Minute Medical Devices Group
Wednesday 12 June 2024 at 2 pm on Teams

Present

Neil McCormick, Director of Property & Asset Management **(Chair)** (NMcC)
Maxine Michie, Deputy Director of Finance (MM)
Rose Robertson, Assistant Director of Finance (RR)
Iain Forrest, Medical Physics Manager (IF)
Donna Galloway, General Manager, Woman, Children & Clinical Services (DG)
Claire Fulton, Lead for Adverse Events, Clinical Governance (CF)
Julia Cook, Infection Control Manager (JC) (joined at 2.40 pm)
John Brown, Head of Pharmacy, Clinical Services (JB)
Claire Steele, Head of Pharmacy, Medicines Supply & Quality (CS)
Robyn Gunn, Head of Laboratory Services (RG)
Alistair Graham, Associate Director of D&I (AG)
Jane Anderson, Radiology Manager (JA)
Richard Scharff, Radiology Clinical Activity Manager (RS)
Aylene Kelman, Consultant Physician & Clinical Director, FHSCP (AK)
Amanda Wong, Director of Allied Health Professionals (AW)
Shirley-Anne Savage, Director of Quality & Clinical Governance (S-AS)
Mike McAdams, Estates Compliance Manager (MMcA)
Paula Lee, Head of Procurement (PL)
Elizabeth Muir, Clinical Effectiveness Manager (EM)

In Attendance

Andrea Barker, Note Taker

The meeting was recorded on Teams
The order of the minute does not necessarily reflect that of the discussion

		Action
1	**WELCOME & APOLOGIES** Members were welcomed to the meeting. Apologies were received from Iain MacLeod, Gemma Couser, Miriam Watts, Nicola Robertson, Kevin Booth & Laura Stewart (Paula Lee).	

2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 13 September 2023 was **a**pproved by the group. Meeting of 13 December 2024 was cancelled due to the high number of apologies received. Meeting of 13 March 2024 was cancelled due to work pressures.	
3	**GOVERNANCE** In terms of the Medical Devices Group, NMcC explained that initially, we struggled in terms of the exact requirement of the group together with our response to National issues around the emergence of medical devices and software as a service and as a potential medical device. Moving forward, under agenda Item 4.3 SGHD/CMO(2024)01 - Medical Device Regulation (MDR) Preparedness and Medical Devices Policy Framework and Action Plan 2024-26 highlights and gives the group an indication of the four areas we should focus on as a group. To date, discussions with colleagues in NHS Forth Valley have taken place requesting the provision of professional support to the group. Internally, Mike McAdams, Estates Compliance Manager has agreed to provide support to the group moving forward.	
4 4.1	**FOR DISCUSSION** Registration of the Laboratory Information Management System Software (LIMS) as a Medical Device RG advised that ILFT is a calculation and, therefore, becomes a medical device. Discussions have taken place with the National LIMS Programme and a number of other parties to ensure we had the requirement correct. This has no implication for NHS Fife. When the National LIMS team take the registration requirement forward and start to implement ILFT across other boards, it will require to be registered as a medical device. NHS Fife will assist the National team with the full national build. NMcC added that RG's explanation gives the group an idea of the complexities involved around registering medical devices with processes that we, as a group, do not fully understand yet. To date, progress has been slower than expected, however, we are not the only Board in this position. After speaking with the Director of Nursing who sits on the National Group, she has indicated that similar	

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	questions on medical devices are being discussed nationally as well as locally. NMcC thanked RG for her helpful update on behalf of the group.	
4.2	<u>Infusion Devices - Volumetric Pump from B Braun</u> Concern was raised by Allan Timmons, Principal Pharmacist, Pharmacy Ambulatory Care who had a particular issue with a Volumetric Pump from B Braun. We escalated this via PL in Procurement to make a formal complaint about B Braun and devices failing. Initially, the response we got back was due to our cleaning regime which did not seem entirely feasible. PL added that as infusion devices are part of a National Contract, she invited the Commodity Manager from National Procurement who joined in with several calls with the supplier. A number of actions were raised and a number of the devices have been returned to the supplier for analysis. On further investigation, cleaning does form part of the concern and Emily Ridley has been working internally with departments who use these devices and she is reviewing the correct procedure for cleaning. Policies on cleaning are being updated and we are linking in with the supplier in terms of the most appropriate cleaning solutions to use. Thirty devices were supplied to us to compensate for the items that have been out of action free of charge. IF advised that B Braun has charged Estates for the cost of the replacement devices and, therefore, do not appear to be free of charge. Tracy Gardiner, Finance is in discussion with the Commodity Manager of B Braun to have this resolved. He added that all replacement devices remain unopened and delivery of spare parts were received around the same time which has resulted in us catching up with the repair backlog to ease pressure. Therefore, the thirty devices can be returned to B Braun if we do not want to pay for them. Cleaning and maintenance remain a concern and company representatives from B Braun continue to visit wards who use the devices to check on their cleaning regimes. IF added that issues continue which are not related to cleaning. We cannot define whether or not our concern was related to a specific batch. The group agreed that this continues to be managed through IF and his Medical Physics team alongside the operational teams who are liaising directly with B Braun.	

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4.3	SGHD/CMO(2024)01 - Medical Device Regulation (MDR) Preparedness and Medical Devices Policy Framework and Action Plan 2024-26 The Scottish Government has recently published a Policy Framework for Medical Devices SGHD/CMO(2024)1 titled: Medical device regulation (MDR) preparedness and medical devices policy framework and action plan 2024-2026 (scot.nhs.uk) This includes an Action Plan for 2024-26 which identifies four themes and resulting actions for Scottish Government, National Services Scotland, Health Improvement Scotland and Scottish Health Boards. Theme 1 - National Guidance NMcC described to the group that while we understand National Guidance, we require local guidance within the Health Board in terms of how we manage risks and issues around medical devices, how we take our functioning system around medical equipment and turn it into a functioning system around medical devices. NHS Fife's Policies and Procedures have been submitted to the National team who have carried out a review of Policies & Procedures from all Scottish Boards and who are now in the process of issuing recommendations. A full day Medical Devices Workshop has been arranged on 13 August 2024 at the Golden Jubilee National Hospital in Glasgow to which NMcC will attend. We are hopeful that over the next few months, the Board will have a better understanding of the Framework moving forward supported by colleagues from NHS Forth Valley and Mike McAdams, Estates Compliance Manager, NHS Fife. Theme 2 - Implementing Scan for Safety Gemma Couser (GC), Associate Director of Quality & Clinical Governance has taken the lead responsibility for taking Scan for Safety forward in Fife. A meeting has been arranged with the National team regarding NHS Fife's position and whether we take on the implementation of Scan for Safety in 2024, with no Policies and Procedures in place or wait until 2025? The group agreed that a Scan for Safety update would be welcome at the next Medical Devices meeting on 11 September 2024. Action - Gemma Couser as lead, to take the Scan for Safety update request forward.	**GC**

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	<u>Action</u> - Andrea to add Scan for Safety Update to the Agenda for the next meeting. Theme 3 - <u>Improving the Information available to Patients about Medical Devices used in their Care</u> Improvements to available patient information will flow after the implementation of Scan for Safety with clear information on what devices have been used in their care. In terms of implants, there will be traceability available on all affected patients. Our responsibility, as a group, will be how we apply the National Guidance on medical device patient information to locally produced information. Theme 4 - <u>Improving Infrastructure for Medical Devices at National Level</u> A National Monitoring and Evaluation Framework and a self-assessment tool for Boards is being developed to support compliance with regulation and existing National Policy Guidance. The National Workforce Planning Process will be used to signal any changes in workforce requirements required for MDR compliance. Consider what we need locally and what policy frameworks we have in place as a Board. Following submission of an SBAR to the Fife Clinical Governance Oversight Group and the Executive Director Group in April 2024, it was felt that it would be better coming back when the Action Plan was more developed in order to take any actions forward. To summarise, NMcC advised that by around September 2024 we should have a more bespoke Action Plan in place. The group agreed that it would be helpful if the Action Plan can be circulated to the group in advance of the next meeting for comment. <u>Action</u> – Circulation of the most up-to-date Action Plan on Medical Device Policies to the group for comment before the next meeting. GC to take this forward. AG advised that there has been a supplementary SLWG looking at software as a medical device and the implications around all of this. There has been a series of engagements taking place at a National level to understand the set of recommendations. If there is anything of note to policy and guidelines then any updates will be passed onto the group.	**Andrea** **GC**

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4.4	R&D Ref 23-023 Pharyngeal Electrical Stimulation (PES) for Post Stroke Dysphagia Scot (PhEAST) IRAS 306761 Update Approved the use of the equipment as part of a trial. Frances has asked for Medical Device Group approval in relation to the above study which hopefully will help to clarify and resolve outstanding queries which were raised in points c) and d) of communication dated 28/9/23. Point C The equipment which will be used in the trial is being supplied by Phagenesis Ltd and not directly by the University of Nottingham. As well as the usual study agreement, we also have a separate Clinical Equipment Loan Agreement with Phagenesis Ltd. On this basis, the Medical Devices Group is happy that there is a separate Clinical Loan Agreement with Phagenesis Ltd. Point D Phagenesis Ltd are listed on the Master Indemnity Register for Scotland (Access the Master Indemnity Register | National Services Scotland (nhs.scot)) which lists companies who have agreed to supply equipment to NHS boards on loan, free or for trial and testing. These suppliers sign a Master Indemnity Agreement (MIA) with NHS Scotland. When suppliers are registered on the MIA this avoids the need for boards to enter into individual agreements for these goods. On this basis, the Medical Devices Group is happy that the supplier is registered on the Master Indemnity Register. PL added that Trial Agreement paperwork will require to be completed. Action - Andrea to forward on communication to PL. Post Meeting Note - Action Complete. Action - PL has agreed to link in with Penny Trotter and Frances Quirk regarding the completion of the Trial Agreement paperwork.	 **Andrea** **PL**
5 5.1	**FOR INFORMATION** MHRA National Patient Safety Alerts - Medical Beds, Trolleys, Bed Rails, Bed Grab Handles & Lateral Turning Devices: Risk of Death from Entrapment or Falls Update MMcA advised that the equipment devices are now being tracked across the VHK site using an RFID (radio frequency identification) passive and active systems. As equipment and beds are moved around the site anyone who has access to Blink can track the movement of equipment.	

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6	In terms of moving forward with the passive system, a label printer was purchased together with a hand-held scanner, with the labels giving a range of 15 metres, which will easily identify equipment with an RFID label in wards etc. Currently awaiting connection to the network at VHK. In time, the intention is to progress to other sites within NHS Fife. NMcC supported the RFID system in terms of: • Being able to identify and track where pieces of equipment are located will improve maintenance resulting in more of our equipment being in good working order • Being able to identify if equipment has been taken to other parts of the hospital without anyone being aware • Being able to locate beds throughout the hospital thus avoiding purchasing or renting extra beds at additional cost The RFID system will be used for more wider medical equipment with a view to: • We can reduce the amount of equipment we have and avoid as much duplication • If we hold less equipment then often expensive maintenance costs will be reduced both internally and externally • If we can identify items of equipment that we can bring in-house for the Medical Physics team to maintain then we can ultimately offer a much better service and be more efficient overall. We are aware that colleagues in NHS Forth Valley have identified surplus equipment which they have been able to sell which works in terms of sustainability by re-using and recycling. Equipment that is no longer useful in Scotland can be recycled and used in the developing countries thus avoiding landfill. Colleagues in NHS Forth Valley have moved onto a Bluetooth system where they can see the journey of a particular piece of equipment and its current location. IF - Within the Patient Safety Alert, there are several actions which are clinical based RAs etc. What assurance do we have that these are being carried out? Action - NMcC to discuss the Patient Safety Alert with IF out with the meeting.	**NMcC/IF**
6	**MINUTES FOR NOTING**	

Unconfirmed

	Copies of the Fife Capital Equipment Management Group minutes, noted below, were distributed to members of the group in advance of the meeting.	
(a) (b) (c) (d) (e) (f)	CEMG Minute of 3 August 2023 CEMG Minute of 7 September 2023 CEMG Minute of 5 October 2023 - meeting cancelled CEMG Minute of 2 November 2023 CEMG Minute of 7 December 2023 CEMG Minute of 1 February 2024	
	There were no comments or questions raised on the CEMG minutes by the group. RR provided an update by advising the group that there is a £1.1m capital equipment budget available to cover core and condemned equipment which leads to very challenging times ahead with limited resources. NMcC added that the situation is the same across Scotland and with no additional capital available, we are limited to what we can do. The formula capital we have has to cover backlog maintenance, equipment, digital and the areas that require to be taken forward in terms of changes to the estate to allow RTP to function. AG asked, in terms of equipment breakages, if there an understanding around a Business Continuity approach in terms of a piece of equipment failing and not being replaced? RR responded - if a piece of equipment breaks and is business critical then this will fall into the Condemned Equipment category with items having to go through a very robust process. If they are approved for replacement then, ultimately, there are less funds available to go round to finance the priorities of other areas. In terms of a Business Continuity approach, if we were to run out of funds, then the component parts of the overall Capital Formulary Group will be raised as a risk through FCIG where a decision on re-prioritisation would be required. NMcC added that it had been agreed and recognised at a recent FCIG meeting that an amount of available funds should be retained to allow for any new priorities that may arise between now and the end of the year. RS advised that in Radiology, there is a quantity of equipment which is at or nearing its end of service which will be added to the Risk Register. Year-on-year the End of Service list increases as the equipment is not being maintained as it should be. NMcC added that we are having to be thoughtful around what does and does not get replaced. A very difficult situation to find ourselves in.	

Unconfirmed

	MM asked if plans are being prepared on the basis of Lifecycle which could be slightly different thus potentially being able to spread the demand over a number of year? Perhaps we could have looked at how we prioritised equipment during Covid? We are receiving the same amount of funding in terms of capital from the Scottish Government (SG) however, we are not in a position to ask for additional funds that are just not there. NMcC - there is a National group across Scotland that he and RR regularly attend. NHS Fife's 5-Year Plan was submitted, however, if you cannot afford to deliver Year One of the plan then it suddenly looks very different. Overall, following submission of 5-Year Plans from Scottish Boards, it was identified that £150m of equipment is required this year, most of which will not be procured resulting in a carry forward to next year's total, of which we are aware that there will be no extra available capital funding. A situation which is challenging all round.	
7	**ANY OTHER BUSINESS** There was none.	
8	**DATE & TIME OF NEXT MEETING** Wednesday 11 September 2023 at 2 pm on Team	

Unconfirmed

MEDICAL & DENTAL PROFESSIONAL STANDARDS OVERSIGHT GROUP **(Meeting on 9 July 2024)**
No issues were raised for escalation to the Clinical Governance Committee.

Medical and Dental Professional Standards Oversight Group
Note of Meeting Held at 3.00 pm on Tuesday, 9th July 2024
on Microsoft Teams

Present:	**Designation:**
Dr C McKenna	Executive Medical Director/Responsible Officer, NHS Fife (Chair)
Dr A Kelman	Associate Medical Director Fife Health & Social Care Partnership
Dr H Hellewell	Deputy Medical Director, Fife Health & Social Care Partnership
Dr M Philp	GP Appraisal Lead
Dr E O'Keefe	Director of Dentistry
Dr J Pickles	LNC Representative
Dr S Savage	Associate Director for Risk and Professional Standards
Dr J Tomlinson	Director of Public Health
Mrs A Gracey	Medical Appraisal & Revalidation Coordinator

Apologies:	
Prof Morwenna Wood	Director of Medical Education
Dr I MacLeod	Deputy Medical Director – NHS Fife Acute
Dr J Morrice	Associate Medical Director, Women and Children
Ms L Cooper	Head of Primary and Preventative Care Services
Dr A Kelman	Associate Medical Director Fife Health & Social Care Partnership
Ms J Anderson	Interim General Manager, Women Children and Clinical Services
Mrs M Watts	General Manager, Surgical Directorate
Dr M Clark	Associate Director of Medical Education
Ms S Ali	Medical Education Manager
Dr K Steel	Associate Director of Medical Education
Dr S McCormack	Associate Medical Director – Medical and Surgical Directorate
Mr E Dunstan	Secondary Care Appraisal Lead
Ms G Couser	Associate Director of Quality and Clinical Governance
Mrs R Waugh	Head of Workforce Planning and Staff Wellbeing

		ACTION
1	**Welcome/Apologies for absence** Apologies noted as above.	
2	**Draft Note of previous meeting (11/04/2024)** Minutes accepted by group as an accurate record.	**DMc**
3	**Action Tracker** **Action**: Emma O'Keefe, Director of Dentistry to be added to the Terms of Reference. **Status – Complete & Closed** **Action**: Medical Education SLT minutes/action tracker to be fed into the group. Further discussions required between SAS and GC to agree what is relevant to bring to this group. **Status: Ongoing** **Action**: ED requested that last year's job plan 'end of year' progress could be shared to allow each Directorate/Specialty to review. AG was asked to share this at the next meeting.	

Status: AG stated that she had asked Allocate to add this as she does not have the access to do this. Agreed to remove this action from the tracker.
Action: Closed.

Action: LC noted that the Partnership E job-plan portfolio wasn't correct. LC to liaise with AG to fix this issue.
Status: Complete & Closed

Action: Medical Workforce Planning – Acute Services and HSCP minutes and terms of reference to be shared with this group,
Status: Ongoing.

Action: SAS/AG to circulate the Framework for Medical Appraisal and Revalidation to the group.
Status: Complete and closed.

4. **Medical Appraisal and Revalidation.**

It was reported that there were 43 doctors due for revalidation between 1st April 2024 and 30th June 2024. 40 were positively recommended and 3 deferrals were made. All 3 deferrals were due to the doctors' intentions to retire.

In secondary care there was 1 new appraiser trained, who is starting imminently, with another due to start their training in September 2024. However, there is also an appraiser stepping down from the role as of 1st September 2024.

There are currently 57 appraisees unallocated. This should be reduced by 10 once the new appraiser starts. Primary Care also have a new appraiser who started on the 1st July 2024, carrying out a half session/week.

Fife data was submitted for the quality assurance exercise in May 2024 and a letter was received saying they were content with the work in Fife (letter attached to this agenda for the groups information). JP asked AG about the 47 unallocated appraisers. It was confirmed that due to the goodwill and flexibility of the current appraisers these appraisals have been covered. This is an ongoing problem.

5. **Consultant and SAS Doctor Job Planning.**

AG shared the current E-job-plan report showing the status by department of the total number of signed off job-plans. Compared with past reports there is progress being made with most of the job-plans.

AK updated the group on the HSCP job plans; all except one are at the 2nd sign off stage; leaving only the 3rd sign off. AK and HH are working on aligning it with Acute with the GMs or similar signing it off. HH is taking forward a paper to **HSCP SLT** to inform them that they will be changing the process and GMs can be sighted first with that final sign off allocation. There was discussion around the need for the 3rd sign off. AG confirmed that she has the ability on Allocate to reduce it to two if required.

Further discussions are required to decide on the sign off process. AK is meeting the GMs to discuss this and create a process for HSCP to ensure that financial and service needs have been discussed to allow sign off.

Action: HH, IM, SMc, AK to discuss the need for the 3rd sign off' and any issues there may be excluding this. **HH/IM/SMc/AK**

6. Medical Education.

There was a discussion around the Medical Education SLT and whether minutes should come to this meeting. GC to recommend what should be tabled at this meeting going forward. **SAS/GC**

Action: SAS to discuss with GC.

7. Dental Education.

EO'K updated the group that in terms of vocational training for dentists coming into practice there are 12 places in Fife, however, only 8 were filled. This will affect NHS Fife Dentistry and our National discussions are English and foreign students coming up to Scotland so difficult to predict who will stay in Scotland.

On a positive note, there is a core trainer joining our Public Dental Service. There are no new ST's this year in Fife and six vocational trainees staying on in Fife with five coming into Fife for associate posts.

8. Medical Workforce Planning – Acute Services/ HSCP.

There was discussion on using a Flash Report to report to this group similar to the one used at the Primary Care Oversight Group. HH updated that the GP tender processes for the practices that are currently looking to convert to a 17J practice is still ongoing. They are looking at further work on recruitment and retention, utilising, portfolio career opportunities, advance practices development to continue to be that expert medical generalist.

To bring work around rheumatology future meeting.

There is also significant work being done in Psychiatry.

Action: HH to share flash report with SAS or AG **HH**

10. Any Other Competent Business.

11. Date, Time and Venue of Next Meeting. – To be confirmed Monday, 14 October 2024 at 3.00pm via Microsoft Teams

Distribution List:
Dr C McKenna, Medical Director – NHS Fife
Dr I MacLeod, Deputy Medical Director – NHS Fife Acute
Dr H Hellewell, Deputy Medical Director – Fife Health & Social Care Partnership
Dr J Tomlinson, Director of Public Health
Dr E O'Keefe, Director of Dentistry
Dr S Savage, Associate Director for Risk and Professional Standards
Ms G Couser, Associate Director of Quality and Clinical Governance
Dr S McCormack, Associate Medical Director – Surgical and Medical Directorate
Dr J Morrice, Associate Medical Director, Women & Children
Dr A Kelman, Associate Medical Director, Fife Health & Social Care Partnership
Ms J Anderson, General Manager, Women, Children & Clinical Services
Ms L Cooper, Head of Primary and Preventative Care Services
Mrs A Gracey, Medical Appraisal and Revalidation Co-ordinator
Dr M Philp, GP Appraisal Lead
Mr E Dunstan, SC Appraisal Lead
Prof Morwenna Wood, Director of Medical Education
Dr M Clark, Associate Director of Medical Education
Dr K Steel, Associate Director of Medical Education
Ms S Ali, Medical Education Manager
Mrs R Waugh, Head of Workforce Planning and Staff Wellbeing
Dr J Pickles, LNC Representative

RESILIENCE FORUM

(Meeting on Thursday 13 June 2024)

- The Severe Weather framework document was ratified by Executive Directors Group on the 1 August 2024.
- Resilience Forum agreed that the HAZMAT/CBRN risk identified with wet decontamination facilities at Victoria Hospital Kirkcaldy will escalate to Executive Directors Group.

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

Minutes of Resilience Forum held on Thursday 13th June 2024 at 1430hrs via Microsoft TEAMs

Chair:
Joy Tomlinson, Director of Public Health, NHS Fife **(JT)**

Present:
Kirsty MacGregor, Director of Communications, NHS Fife **(KMcG)**
Susan Cameron, Head of Resilience, NHS Fife **(SC)**
Sharon Docherty, Consultant Psychologist, NHS Fife **(SD)**
Avril Sweeney, Risk Compliance Manager, NHS Fife **(AS)**
Lynne Parsons, Employee Director, NHS Fife **(LP)**
Susan Fraser, Associate Director of Planning and Performance, NHS Fife **(SF)**
Jeremy Stewart, Emergency Planning Officer, NHS Fife **(JS)**
Holly Jones, Project Support Officer, NHS Fife **(HJ)**
Aileen Boags, Lead Pharmacist, Public Health/Community NHS Fife **(AB)**
Allan Young, Head of Digital Operations, NHS Fife **(AY)**
Jamie Doyle, Head of Nursing, NHS Fife (start until 48mins) **(JD)**
Jimmy Ramsay, Head of Sustainability, NHS Fife **(JR)**
Maggie Currer, Consultant, Emergency Department, NHS Fife **(MC)**
(17mins until end)
Tanya Lonergan, Head of Nursing, NHS Fife **(TL)**
(1hr 36min until 1hr 46min

In attendance:
Minutes prepared from Microsoft Teams by Stevie Rutherford **(SRR)**

Agenda Item **Action**

1. **Welcome and Introductions**

   JT opened the forum.

2. **Apologies**

   Stevie Rutherford, Lynne Garvey, Nicola Robertson, Craig Burns

3. **Minutes of Previous Meeting (13th March, 2024)**

   JT accepted the minutes as accurate after consulting the forum for feedback.

3.1 Action Tracker from 13th March 2024

SC provided an overview of the action tracker

- Severe Weather Framework
  Tabled with Executive Directors Group (EDG) for agreement.

- Vulnerable Person's – Patient at Risk Database (PARD)
  Action paused. Advice that a national care for people work will consider the wide range of response activity require to support those who have been impacted by an incident. Fife LRP are looking to the re-establishment of a national care for people group which will support care for vulnerable people.

- Bomb Threat & Suspicious Package Framework Document

  EDG approved in April, 2024. Action complete

- CBRN/HAZMAT
  On the agenda for discussion.

- NHS Fife's Incident Management Framework
  Meeting representatives were advised that this response document is now due for another key stakeholder review

4.0 Matters Arising

4.1 <u>Scottish Government organisational design – LRP Partner Report</u>

JT advised the forum that the partner update was shared at the Fife Resilience Partnership meeting, noted that there is strong support in our local resilience partnership from Scottish government co-ordinators. A review is underway within the justice department of Scottish Government. The implications are that there may be less support or indeed no support in future for local resilience partnerships. JT advised this paper is for awareness.

4.2 <u>LRP National Care for people gaps</u>

This paper was tabled at the Fife Local Resilience Partnership (LRP) meeting.

JT advised the forum that the National Care for People group which would look at gaps and clarify agency roles, that this work has been paused presently.

Shona Robertson, Resilience Manager, Fife Council has agreed to pull together a group for Fife keeping things moving as much as we can in our local area. SC advised Care for People issues were highlighted through the exercise Operation Waypoint which entailed evacuation of a cruise ship; this took place at Forth ports.

SC and AB are currently working together on mass prescribing for Care for People and anticipate will be part of the local Fife Care for People group.

5.0 Resilience Governance & Assurance

5.1 <u>Quarter 4 EPRR Report</u>

SC provided an overview of the quarter 4 report which was themed on business continuity. The report describes business continuity progress, testing and exercise training and staff attendances. SC advised testing and exercising is a rolling programme, and continues to be phased in across NHS Fife service areas.
A suite of testing and exercise scenarios testing is supported by the resilience team online.

Health and Social Care Partnership are continuing to work through remaining business continuity plans due for review. FHSCP have enabled a pack for their services to further raise awareness on business continuity.

5.2 BC Dashboard Assurance (whole system)

The business continuity dashboard slide was presented by HJ.
SF enquired how the business continuity plans are changed to reflect infrastructure changes agreed as part of Re-form, Transform & Perform (RTP). She suggested one of the resilience team should be invited along to the infrastructure group, and noted that business continuity should be considered as part of the ongoing programme of infrastructure changes which will result in relocation of staff. SF agreed to ask that SC is added to the RTP meeting group.

ACTION – SC to join RTP working group **SF**
ACTION – SC and SF to catch up re RTP **SC/SF**

5.3 C3 B13-23 Audit S Bar & Action Planning

JS provided an overview of the SBAR and the Action Plan which has been developed in response to the findings from this audit. This will be submitted to EDG for their meeting on 20th June. SC advised one of the next key next steps will be development of NHS Fife's business continuity policy.

Now that we are in a position where we have launched business continuity management systems approach, moving forward the draft document will be coming to the forum and will be circulated around key stakeholders for feedback.

JS highlighted the recommendation and associated action within the plan on testing and exercising, and described the balance between capacity and outreach, getting engagement to then promote testing.

There is no mandated training currently for plan manager and owners, this is an identified gap. SC advised this is a national gap, and an area for future development nationally.

ACTION – Draft BC Policy to be brought to the next meeting in September. **JS**

SC advised there was a debrief following the SGN gas networks work that took place outside Victoria hospital. General Practices (GP) have been offered support with access to our business continuity templates. Resilience team have offered support with business continuity planning to their manager's network. This would be beneficial and in line with the national strategic guidance for business continuity. Practice managers have been offered resilience support where we can add their BC details into our Dashboard so that we can help them monitor when their plans are due for review & with exercise scenario testing.

6.0 Whole System Overview Part 2

6.1 Embedding welfare support and psychological safety preventative training

SD provided a presentation of the psychosocial and mental health (PSMH) needs of people affected by emergencies.

SD highlighted that existing Preparing Scotland 2013 guidance includes responding to psychosocial and mental health needs of people affected by emergencies.

SD noted that emergencies affect people psychologically, socially and emotionally. Planning is an important part of the incident management response to reduce suffering as much as possible.
SD provided an overview of psychological first aid approach and set of interventional principles to guide and inform intervention and prevention efforts. In summary:

- Majority of individuals benefit from psychological first aid
- Minority will require screening/monitoring
- Some people will have specific support requirements, such as those with underlying mental health issues or the bereaved

Intervention principles aim to calm the stress response.

SD updated that Jill Torrance is supportive of the proposal to form a psychosocial and mental health incident response cell for NHS Fife.

A draft SBAR has been completed and ready to brief the senior Leadership Team (SLT). Service feedback been submitted to inform the revision of the NHS Fife Framework, SC and SD have had conversations around what training modules are available for staff.

SD was invited to join a future H&SCP meeting and deliver this presentation.

ACTION – SD to share slides she presented **(SD)**
ACTION – SD to attend & present at HSCP forum meeting **(SD)**

6.2 FHSCP – Care for people/PARD

PARD was discussed earlier in the meeting. At national level work has been paused. An Internal Audit report has been carried out for the Integrated Joint Board (IJB) on resilience and business continuity, and the report has now been received. The IJB Internal Audit report also referred to the B13-23 audit report discussed under item 5.3 on today's agenda.

6.3 SAS

No update for this meeting.

6.4 Acute Services

6.4 a) An overview was provided of the revised Missing patient procedure from Head of Nursing (TL)

TL advised that she has been working alongside SC and Jamie Doyle to review NHS Fife's missing person's procedure.

Procedure changes include:

1. Risk categories have been simplified to Low or High. High risk individuals are at risk from harm to themselves or others and the procedure sets out how staff should contact Police Scotland for assistance. High risk Includes people who need urgent medical treatment or serious physical concerns, vulnerable adults, and young people under 18 years of age.

2. Work has been completed with Police Scotland to agree a handover process. Clinical areas have supplementary flow charts; (Emergency Department & HSCP Forensic services)

TL advised another piece of work that has been carried out is to agree definition of a missing person, for example someone from a ward that is in the cafe should not be classed in this bracket as staff know where the individual is.

TL further advised the forum that data and information/actions have been tightened up and governance, roles and responsibilities, risk management and documentation improved. It is anticipated the updated procedure will be ratified at the end of the month.

TL and JD would be happy to receive any feedback from forum members. Security team are aware of this procedure and also note that due to changes in information governance, potential updates to NHS CCTV procedures may be needed. JT advised the forum to provide feedback to TL by 21st June, 2024.

ACTION – feedback on the missing patient procedure by 21st June **ALL**

6.4 b) Risk ownership VHK ED wet decontamination room (Draft Risk Assessment)

SC reminded the forum that an SBAR has previously been tabled about this risk. The risk relates to an issue with the wet decontamination drainage which means that the room cannot be used in the case of incident response. There is also a separate issue with the decontamination tent. The manufacturer has confirmed that the lifespan of the tent material has expired and they cannot extend the warranty further. Estates have been exploring solutions to make good the drainage assessing the risks but this would come at a cost. There is uncertainty about ownership of the risk, whether this would fit better with capital planning / procurement team.

MC confirmed that if we have an CBRN event at VHK hospital and patients need to be decontaminated at the hospital the phase 3 room that was constructed for this purpose, as the drainage goes into the main drainage system and not a standalone sump.

MC advised the plan would be that any patients reporting to the department would be decontaminated in the tent which would be erected outside the decontamination room for showering people with warm water. This is not ideal as there is also an environmental risk to people being showered outside the building. The other problem is that the manufacturer is now unable to guarantee the structural integrity of the tent.

MC advised this is one of the lower risks but although still a level of risk if we had a CBRN event is high. At present our only option is to use a non guaranteed tent and to use the drainage collection system which currently works as collecting the water within the tent, the runoff of the water goes into bags and then is disposed via Hepa regulations depending on information of the contaminant. The structure of the tent is no longer guaranteed. If there were to be a leak and cause environmental damage, NHS Fife would be liable for this potentially. After discussion with NHS Fife Health and Safety team they felt this was an extreme risk.

MC advised the two mains things that need to be addressed are, who owns the risk, and whether the tent is used in the case that we need it. There has been discussion about risk ownership sitting with the emergency care directorate. MD cautioned

against this approach as the risk is an organisation risk and not a departmental risk Any decision to use the decontamination tent needs to be taken at organisational level, is not the directorates decision.
There are two potential solutions, build modifications to the original decontamination room, noting the pressures on capital spend, or buy a new tent. The alternative is to tolerate the risk and that there may be a high consequence in terms of both outcome and cost

SC advised there was discussions with estates and seeking to obtain quotes through Equans who is the original manufacturer, PFI provider involved, or a work around was to pump water out to an external bladder.

JT, noted the correct links have been made so far, but a conversation will be needed with the Director of property and asset management to determine the risk ownership.

MC advised the tent was purchased for the Dunfermline site more than 20 years ago when the emergency department was located in Dunfermline, an extension to the manufacturer's warranty/guarantee was provided by the manufacturer, around the time the emergency department relocated to Kirkcaldy.

MC advised if there is a CBRN incident the Ambulance SORT team would usually decontaminate on scene and not need to be carried out again at the hospital. It is likely that some people will bypass this offer and present at the hospital. Access to Ambulance SORT facilities cannot be guaranteed and there remains a need for physical decontamination at VHK site.

JT noted that discussion with Executive Directors is required to clarify risk ownership. There is a clear recommendation from the forum that clarification is needed for risk ownership this will be escalated to Executive Directors Group (EDG). JT advised to add to our own action log in the meantime.

ACTION – Escalated to Executive Directors Group **SC**

6.5 CCRA Team

JR advised the forum there are two main pieces of work underway. These are flooding and overheating. Yasmine Morgan has been updating executive groups on these risks.

An email has been sent to Clare Dobson and Jeanette Keenan, to identify overheating impacting on wards.

Two wards have reported overheating regularly. These are Mayfield Ward in Lynebank and Muirview Ward in Stratheden.

Full building plans have been pulled for these wards and sent to the sustainability manager within NHS.

Flood management discussions have been underway with SC to work out how to build into business continuity plans, and conversations to take place with Estates at a later date.

Yasmine Morgan is currently assessing the flooding risk at all sites. Part of Yasmin's work is to raise awareness of potential flood risk, and emergency planning

procedures. She is also updating flood assessments using a climate mapping tool. Detailed and in depth flood risk assessments are in place already.

SC suggested that her field based learning student (FBLO) from Stirling University could benefit from contact with JR's team. FBLO will complete a project with a focus on multi-agency major incident response and humanitarian aid looking at intelligence with regional events such as landslides caused by heavy rainfall or heavy weather conditions.

6.6 Digital & Information

AY presented slides onscreen.

AY advised there remains a high threat status according to the national cyber security centre. Criminal gangs are leading attacks in the West, including hospitals in the UK. An attack occurred in London and Scotland recently. Average cyber incidents and alerts have gone down in the last quarter. New vulnerabilities have come down slightly.

Dumfries and Galloway suffered a sophisticated cyber attack in February 2024 which involved human factors. AY displayed the cyber response planning slide. Generally the cyber attack originates from a phishing email.

CSOC continues to send out alerts for vulnerabilities. Cyber Resilience Early Warning (CREW) alerts come from directly from Scottish Government. Network and information systems interim audit is imminent. AY's team are collating all the red items from last years audit. The submission date for this year's audit is 01st July, 2024. Report due back on 26th August, 2024.

SC raised a concern about the potential vulnerability of digital swipe cards within hospitals, and if these are hacked then we could not lockdown the hospital in question. AY advised that his cyber security manager Margaret Harris is going to discuss this risk with digital's new Police Scotland's contact who has offered a joint tabletop exercise.

7.0 Emergency Plans

7.1 LRP Power Outage plan (Resilience Direct)

SC advised our LRP and multi agency partners have been in consultation about our power outage plan for Fife. This plan is now available on Resilience Direct, it includes guidance on what actions would be put in place if a serious power outage takes place.

8.0 Training & Exercising

8.1 Winter Vaccine Table Top Exercise – debrief learning actions

JS highlighted the follow up actions from the report. A cold de-brief took place in February, 2024 and informed the actions. SC advised follow up actions would be monitored by the Community Immunisation Service Programme Board programme, the resilience team sponsored the de-brief but actions and follow up actions sit with the Community Immunisation team.

9. Fife Regional Resilience Events Brief

- Save the date 26 August Nitazenes Scenario

HJ circulated the events brief to include multi agency exercises and events happening all across Fife. MC and the drug liaison team are hosting a Nitazenes Scenario on the 26th August and SC advised forum members to save the date.

10. National Updates:

- National Incident Response Levels – Guidance for Health Board in Scotland

- Scottish Government have issued new guidance for the NHS national incident response levels, link included NHS National Incident Response Levels - Guidance for Health Boards in Scotland (www.gov.scot) Meeting reps are navigated to this for awareness.

- Revised Prevent duty guidance: for Scotland (2015)

A revised document was issued nationally in May, 2024, this guidance is for health, and health and social care along with multi agency teams for how we respond to Prevent awareness. Work is ongoing in the background to enable new Prevent training, there are 4 new training offerings provided by the cabinet office. These will be linked into Turas for colleagues to access, an update will be provided in due course.

NHS staff are required to undertake an update every two years, this will be on the core framework for NHS Fife, additional information on the Stafflink web pages. We will circulate through the Resilience workforce brief and link in with our Communications Team for additional cascading.

SC updated meeting reps that the 26th August Nitazenes Scenario event will be provided at VHK. The aim is to invite a range of disciplines including public health consultants on call, Emergency Department, Drugs advisory and liaison teams and services. SC advised she has opened the invitation to our local resilience partners and multi agency teams and the event will take place at the education centre.

11. Any other business

None

12. Date of next meeting:

12.1 Schedule of meetings for 2024

11th September 2024
12th December 2024