NHS Fife Clinical Governance Committee

Fri 01 November 2024, 10:00 - 12:55

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 6 September 2024

Enclosed *Arlene Wood*

Approval

Item 03 - Clinical Governance Committee Minutes (unconfirmed) 20240906.pdf (14 pages)

10:00 - 10:00
0 min

4. Chair's Assurance Report presented to Fife NHS Board on 25 September 2024

Enclosed *Arlene Wood*

For information

Item 04 - CGC Chair's Assurance Report 20240906.pdf (5 pages)

10:00 - 10:15
15 min

5. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 05 - CGC Action List 20241101.pdf (4 pages)

10:15 - 10:35
20 min

6. ACTIVE OR EMERGING ISSUES

6.1. East Region Neonatal Services

Enclosed *Claire Dobson / Aileen Lawrie*

Discussion

Item 06.1 - SBAR East Region Neonatal Services.pdf (7 pages)
Item 06.1 - Appendix 1 Demand Capacity Modelling NICU Services Final Report.pdf (56 pages)

6.2. Orthopaedic Hip Fracture Audit

Enclosed *Iain McLeod*

Assurance

- Item 06.2 - SBAR Orthopaedic Hip Fracture Audit.pdf (7 pages)

10:35 - 10:55
20 min

7. GOVERNANCE MATTERS

7.1. Clinical Governance Oversight Group Assurance Summary from [insert date] Meeting

Enclosed *Gemma Couser*

Assurance

- Item 07.1 - Clinical Governance Oversight Group Assurance Summary.pdf (5 pages)

7.2. Corporate Risks Aligned to Clinical Governance Committee, including update on Cancer Waiting Times

Enclosed *Dr Shirley-Anne Savage / Claire Dobson*

Assurance

- Item 07.2 - SBAR Corporate Risks Aligned to Clinical Governance Committee.pdf (8 pages)
- Item 07.2 - Appendix 1 NHS Fife Corporate Risk Register as at 18 October 2024 CGC.pdf (6 pages)
- Item 07.2 - Appendix 2 Assurance Principles October 2024.pdf (1 pages)
- Item 07.2 - Appendix 3 Risk Matrix.pdf (2 pages)

7.3. Delivery of Annual Workplan 2024/25

Enclosed *Gemma Couser*

Assurance

- Item 07.3 - Delivery of Annual Workplan 2024-25.pdf (8 pages)

10:55 - 11:15
20 min

8. STRATEGY / PLANNING

8.1. Annual Delivery Plan 2024/25 Quarter 2 Report

Enclosed *Margo McGurk*

Decision

- Item 08.1 - SBAR Annual Delivery Plan 2024-25 Quarter 2 Report.pdf (5 pages)
- Item 08.1 - Appendix 1 Annual Delivery Plan 2024-25 Quarter 2 Report.pdf (38 pages)

8.2. Clinical Governance & Strategic Framework Delivery Plan Mid-Year Review 2024/25

Enclosed *Gemma Couser*

Assurance

- Item 08.2 - SBAR Clinical Governance & Strategic Framework Delivery Plan Mid-Year Review 2024-25.pdf (3 pages)
- Item 08.2 - Appendix 1 Clinical Governance & Strategic Framework Delivery Plan Mid-Year Review 202425.pdf (3 pages)

8.3. Cancer Strategic Framework & Delivery Plan Update

Enclosed *Dr Chris McKenna / Shirley-Anne Savage*

Assurance

- Item 08.3 - SBAR Cancer Strategic Framework & Delivery Plan Update.pdf (5 pages)
- Item 08.3 - Appendix 1 Cancer Strategic Framework & Delivery Plan Update.pdf (31 pages)

11:15 - 11:45

9. QUALITY / PERFORMANCE

30 min

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 (7 pages)
- Item 09.2 - Appendix 1 Healthcare Associated Infection Report.pdf (26 pages)

9.3. Rapid Cancer Diagnostics Services

Enclosed *Dr Chris McKenna*

Assurance

- Item 09.3 - SBAR Rapid Cancer Diagnostics Services Update + Appendices 1 & 2.pdf (7 pages)
- Item 09.3 - Appendix 3 NHS Fife Rapid Cancer Diagnostic Service Report.pdf (29 pages)
- Item 09.3 - Appendix 4 SLT financial Impact of RCDS.pdf (10 pages)
- Item 09.3 - Appendix 5 NHS Fife RCDS –GI report.pdf (6 pages)

9.4. Adverse Events Improvement Plan

Enclosed *Gemma Couser*

Assurance

- Item 09.4 - SBAR Adverse Events Improvement Plan Update.pdf (19 pages)

11:45 - 11:55
10 min

10. DIGITAL & INFORMATION

10.1. Briefing on the NHS Dumfries and Galloway Cyber Incident

Enclosed *Alistair Graham*

Assurance

- Item 10.1 - SBAR Briefing on the NHS Dumfries and Galloway Cyber Incident + Appendices.pdf (9 pages)

10.2. Briefing Paper for Digital Strategic Framework Timeline Update

Enclosed *Alistair Graham*

Assurance

- Item 10.2 - SBAR Briefing Paper for Digital Strategic Framework Timeline Update.pdf (13 pages)

11:55 - 12:05
10 min

11. PROFESSIONAL STANDARDS

11.1. Professional Standards Group Update

Enclosed *Dr Chris McKenna / Dr Shirley-Anne Savage*

Assurance

- Item 11.1 - SBAR Medical and Dental Professional Standards Oversight Group Update.pdf (4 pages)

Item 11.1 - Appendix 1 Medical and Dental Professional Standards Oversight Group - Terms of Reference Feb 2024 v0.2.pdf (2 pages)

12:05 - 12:25
20 min

12. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

12.1. Patient Story

Presentation *Janette Keenan*

Assurance

12.2. Patient Experience & Feedback

Enclosed *Janette Keenan*

Assurance

- Item 12.2 - SBAR Patient Experience & Feedback Report.pdf (10 pages)
- Item 12.2 - Appendix 1 Patient Experience & Feedback Report.pdf (16 pages)
- Item 12.2 - Appendix 2 Patient Experience Flashcard.pdf (4 pages)

12:25 - 12:50
25 min

13. ANNUAL REPORTS / OTHER REPORTS

13.1. Hospital Standardised Mortality Ratio (HSMR) Update Report 2023/24

Enclosed *Dr Chris McKenna*

Assurance

- Item 13.1 - SBAR Hospital Standardised Mortality Ratio Update Report 2023-24.pdf (4 pages)

13.2. Medical Appraisal and Revalidation Annual Report 2023/24

Enclosed *Dr Chris McKenna / Dr Shirley-Anne Savage*

Assurance

- Item 13.2 - SBAR Medical Appraisal and Revalidation Annual Report 2023-24.pdf (3 pages)
- Item 13.2 - Appendix 1 Medical Appraisal Revalidation Report 2023-24 Final.pdf (8 pages)

13.3. Medicine Safety Review and Improvement Report 2023/24

Enclosed *Fiona Forrest*

Assurance

- Item 13.3 - SBAR Medicine Safety Review and Improvement Report 2023-24.pdf (4 pages)
- Item 13.3 - Appendix 1 Medicine Safety Review and Improvement Report 2023-24.pdf (32 pages)

13.4. Prevention & Control of Infection Annual Report 2023/24

Enclosed *Janette Keenan*

Assurance

- Item 13.4 - SBAR Prevention & Control of Infection Annual Report 2023.pdf (7 pages)
- Item 13.4 - Appendix 1 Prevention & Control of Infection Annual Report 2023.pdf (49 pages)

12:50 - 12:55
5 min

14. LINKED COMMITTEE MINUTES

14.1. Area Medical Committee held on 13 August 2024 (unconfirmed)

Enclosed

- Item 14.1 - Minute Cover Paper.pdf (1 pages)
- Item 14.1 - Area Medical Committee Minutes (unconfirmed) 20240813.pdf (6 pages)

14.2. Cancer Governance & Strategy Group held on 15 August 2024 (unconfirmed)

Enclosed

- Item 14.2 - Minute Cover Paper.pdf (1 pages)
- Item 14.2 - Cancer Governance & Strategy Group Minutes 20240814.pdf (9 pages)

14.3. Digital & Information Board held on 23 July 2024 (unconfirmed)

Enclosed

- Item 14.3 - Minute Cover Paper.pdf (1 pages)
- Item 14.3 - Digital & Information Board Minutes (unconfirmed) 20240723.pdf (5 pages)

14.4. Fife Area Drugs & Therapeutic Committee held on 21 August 2024 (unconfirmed)

Enclosed

- Item 14.4 - Minute Cover Paper.pdf (1 pages)
- Item 14.4 - Fife Area Drugs & Therapeutic Committee Minutes (unconfirmed) 20240821.pdf (8 pages)

14.5. Health & Safety Subcommittee held on 6 September 2024 (unconfirmed)

Enclosed

- Item 14.5 - Minute Cover Paper.pdf (1 pages)
- Item 14.5 - Health & Safety Subcommittee Minutes 20240906.pdf (6 pages)

14.6. Information Governance & Security Steering Group held on 17 July 2024 (unconfirmed)

Enclosed

- Item 14.6 - Minute Cover Paper.pdf (1 pages)
- Item 14.6 - Information Governance & Security Steering Group Minutes (confirmed) 20240717.pdf (4 pages)

14.7. Medical Devices held on 11 September 2024 (unconfirmed)

Enclosed

- Item 14.7 - Minute Cover Paper.pdf (1 pages)
- Item 14.7 - Medical Devices Group Minute 20240911.pdf (6 pages)

14.8. Medical and Dental Professional Standards Oversight Group held on 14 October 2024 (unconfirmed)

Enclosed

- Item 14.8 - Minute Cover Paper.pdf (1 pages)
- Item 14.8 - Medical and Dental Professional Standards Oversight Group Minutes 20241014.pdf (5 pages)

14.9. Infection Control Committee held on 1 October 2024 (unconfirmed)

Enclosed

- Item 14.9 - Minute Cover Paper.pdf (1 pages)
- Item 14.9 - Infection Control Committee Minutes (unconfirmed) 20241001.pdf (4 pages)

12:55 - 12:55
0 min

15. ESCALATION OF ISSUES TO NHS FIFE BOARD

15.1. To the Board in the IPQR Summary

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

12:55 - 12:55
0 min

16. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR’S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 26 NOVEMBER 2024

12:55 - 12:55
0 min

17. ANY OTHER BUSINESS

12:55 - 12:55
0 min

18. DATE OF NEXT MEETING - FRIDAY 17 JANUARY 2025 FROM 10AM - 1PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 6 SEPTEMBER 2024 AT 10AM VIA MS TEAMS

Present:
Arlene Wood, Non-Executive Member (Chair)
Jo Bennett, Non-Executive Member
Anne Haston, Non-Executive Member
Colin Grieve, Non-Executive Member
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Lynne Parsons, Interim Area Partnership Forum Representative
Carol Potter, Chief Executive

In Attendance:
Gemma Couser, Associate Director of Quality & Clinical Governance
Claire Dobson, Director of Acute Services
Jamie Doyle, Head of Nursing *(deputising for Norma Beveridge)*
Fiona Forrest, Acting Director of Pharmacy & Medicines
Susan Fraser, Associate Director of Planning & Performance *(item 8.1 only)*
Alistair Graham, Director of Digital & Information
Ben Hannan, Director of Reform & Transformation
Helen Hellewell, Deputy Medical Director, Health & Social Care Partnership (HSCP)
Neil McCormick, Director of Property & Asset Management *(items 1 – 5.1 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
Nicola Robertson, Director of Nursing, Corporate
Dr Shirley-Anne Savage, Associate Director for Risk & Professional Standards
Gavin Simpson, Anaesthetics Consultant *(item 9.5 only)*
Amanda Wong, Director of Allied Health Professionals
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, Non-Executive Director, who has joined the Committee as a new member.

The Chair also extended a warm welcome to Lynne Parsons, Employee Director, who has joined the Committee as the Interim Area Partnership Forum representative, replacing Liam Mackie, who has been seconded to the Royal College of Nursing.

The Chair advised that Nicola Robertson, Lynn Barker, Norma Beveridge and Amanda Wong have re-joined the Committee as regular attendees, and they were each welcomed to the meeting.

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 Kirstie Macdonald (Non-Executive Whistleblowing Champion), Aileen Lawrie (Area Clinical Forum Representative), Joy Tomlinson (Director of Public Health) and routine attendees Lynn Barker (Director of Nursing, Health & Social Care Partnership), Norma Beveridge (Director of Nursing, Acute), Kirsty McGregor (Director of Communications & Engagement) and Margo McGurk (Director of Finance & Strategy).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of Previous Meeting – Friday 12 July 2024

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

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

The Chair's Assurance Report was presented to the Committee for information only.

5. Matters Arising / Action List

The Committee agreed to the removal of the RAG status for the numbers of adverse events within the Integrated Performance & Quality Report (IPQR).

It was confirmed that further detail around mental health is included within the IPQR, and the Chair requested that mental health incidents, in terms of the most common themes, be added to the next iteration of the IPQR.

Action: Interim Director of Health & Social Care

It was also confirmed that the detail around the reducing restrictive practice improvement work, and the impact this work has on use of restraint, physical violence and self-harm, has been added to the IPQR.

5.1 Reinforced Autoclaved Aerated Concrete (RAAC) Update

The Director of Property & Asset Management noted that the update provided gives the detail of the final survey results undertaken to identify RAAC within the NHS Fife estate. It was reported that, of the seven blocks where RAAC has been discovered, four blocks are stable and annual monitoring will be undertaken to ensure no deterioration of the condition of the material. Three areas require further attention, and, for these, risk assessments have been undertaken and appropriate mitigations put in place. It was highlighted that two additional areas, one at Adamson Hospital and one at Glenrothes Hospital, have now been identified as containing RAAC, since the previous report, and assurance was provided that there is no risk to patients or staff. It was noted that there is no requirement for a business continuity plan for RAAC separately and that this is being built into existing service continuity plans.

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

5.2 Briefing Paper: Alcohol and Drug Death Reviews in Fife

The Medical Director advised that the briefing paper sets out the current position and plans to address the backlog of alcohol & drug death reviews. It was reported that the prevalence of drug and alcohol deaths remains a significant issue in Scotland, and that, following the spike in 2023 of drug deaths in younger people, a separate whole system review was carried out, which was multi-agency.

It was reported that the main challenges for carrying out reviews is due to available resource, and the plans to address these challenges are detailed in the paper. Following a query from the Chair, it was advised that the resource challenge is due to the high number of incidents that require to be reviewed, and assurance was provided that the team are closely monitoring the number of reviews coming forward. Further assurance was provided that the review process is robust.

It was confirmed that there is third sector representative within the multi-agency review group and that the group is aligned to the Alcohol Drug Partnership, with delivery services inputting into reviews.

The Medical Director agreed to provide a further paper to the Committee around the improvements and measures for cluster reviews.

Action: Medical Director

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

5.3 Reform, Transform, Perform - Acute Services Redesign Programme Phase 1

The Director of Acute Services reported that 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. It was advised that this work will be undertaken with immediate effect, and that Phase 1 will conclude by the end of March 2025. Further detail was provided on the programme, with it being noted that this is a clinically driven and multi-disciplinary process.

An overview was provided on the metrics that are in place for monitoring quality indicators throughout the change process. Assurance was provided that they will be closely monitored.

Following questions, the risks and mitigations associated with the formation of the Acute respiratory unit were highlighted. It was reported that workforce and enhancements will form part of the next phase of the programme, and that the focus for the forthcoming months is around co-location and maximising current assets and resources.

The Chief Executive acknowledged and thanked the Director of Acute Services, Deputy Medical Director and their teams for all their hard work.

The Committee took a **“moderate” level of assurance** in relation to Phase 1 of the Acute Service Redesign Programme and **endorsed** the programme from a quality & safety perspective.

6. ACTIVE OR EMERGING ISSUES

The Chair advised the Committee that there are no active or emerging issues.

7. GOVERNANCE MATTERS

7.1 Clinical Governance Oversight Group (CGOG) Assurance Summary from 20 August 2024 Meeting

The Associate Director of Quality & Clinical Governance provided an overview on the assurance summary and advised that the CGOG accepted the draft Duty of Care Policy & Procedural Guidance, with a final version going to their next meeting. It was advised that an update and an improvement plan, in relation to the Scottish National Audit Programme, through Public Health Scotland, will come to the Clinical Governance Committee in November 2024. It was also advised that the output for the hip fracture audit work will come forward to the Clinical Governance Committee. Assurance was provided that a review has been completed on trauma services within NHS Fife, and that improvement options are being worked through.

An overview was provided on the new standardised investigation template for complaints that has been rolled out across the whole system.

Following a query from the Chair, it was advised that there is no concern for the mortality rates reported for cardiac arrests, which were within expected ranges.

The Associate Director of Quality & Clinical Governance was pleased to report that an excellent piece of work around a support pathway for staff involved in adverse events received unanimous support from the CGOG.

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

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

The Associate Director for Risk & Professional Standards provided an update on the corporate risks aligned to the Committee and reported that the mitigations for the quality & safety risk have been updated, and that a Board Development Session was recently held on organisational learning.

The Medical Director provided background detail to the Clinical Optimal Outcomes risk and advised that, through discussions at the Committee’s meeting in March 2024, and through discussions at the Risk & Opportunities Group and the Executive Directors Group, there is an opportunity to develop a revised risk. A comment was made that the Optimal Clinical Outcomes risk description is broad and requires more focus. The importance of ensuring that the corporate risks aligned to the Committee are clear on the quality & safety aspects was discussed. It was noted that once the Board’s risk appetite is agreed, a review of all the corporate risks will be carried out.

The Medical Director agreed to take forward a mapping exercise in terms of the risks aligned to the Clinical Governance Committee, what is being measured and any gaps. The Committee **agreed** that a revised Optimal Clinical Outcomes risk be brought back to the Committee in November 2024.

Action: Medical Director

The Committee **endorsed** a recommendation to the NHS Fife Board for the removal of the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to be tracked instead as an operational risk. It was advised that any changes or proposals around off-site sterilisation would be managed through the Reform, Transform, Perform programme of work.

Action: Medical Director

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.

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

The Committee **agreed** to the proposed Clinical Governance Committee dates for 2025/26, for onward approval of the Corporate Calendar at the NHS Board meeting in September 2024. It was noted that there will be advanced planning for Committee Development Sessions, and these dates will be communicated in plenty of time to members.

7.4 Delivery of Annual Workplan 2024/25

The Director of Quality & Clinical Governance highlighted the addition of the Patient Story at each meeting, and the additions of the Cancer Waiting Times risk, access to outpatient, diagnostic and treatment risk, and Whole System Capacity risk, to the workplan.

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

8. STRATEGY / PLANNING

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

The Associate Director of Planning & Performance joined the meeting and advised that the paper presents the response from NHS Fife to the Scottish Government feedback to our acceptance letter of the Annual Delivery Plan and the Quarter 1 Report.

It was reported that there are 194 actions within the Quarter 1 Report in terms of the Annual Delivery Plan and agreement has been made with the Scottish Government that 78 actions are part of strategic priority to improve quality of health and care services. It was further reported that eight actions were marked as red, which are unlikely to be completed on time or meet the target within the reportable year. These include two actions related to the Clinical Governance Committee, namely: Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and Development of a new outpatient specialist Gynaecology Unit. It was confirmed that

there is no immediate risk that needs to be escalated in terms of the Gynaecology Unit and that there is ongoing work around providing that service in the future. It was advised that future annual reporting of the Annual Delivery Plan will also include actions from the Reform, Transform, Perform workstreams.

Following a question, it was reported that we are currently on track with our trajectories for the radiology mobile funding, although it is anticipated that there will be no funding for Quarter 2, which will be a significant risk.

The Committee **endorsed** submission of the Quarter 1 update and response to Annual Delivery Plan feedback to Scottish Government and took a **"moderate" level of assurance** from the report.

8.2 Scottish Healthcare Associated Infection Strategy 2023-25 Update

The Director of Nursing provided an update on the progress of the Scottish Healthcare Associated Infection Strategy 2023-25, as detailed in the paper, and noted that there are no outstanding matters for the Committee.

The Committee took a **"significant" level of assurance**, noting the national work is continuing.

9. QUALITY / PERFORMANCE

9.1 Integrated Performance & Quality Report (IPQR)

The Director of Nursing reported on the clinical governance aspects of the IPQR and advised that there were 38 extreme adverse events reported in June 2024. It was advised that incidents of pressure ulcer developing on the ward was the most reported major or extreme incident, followed by cardiac arrest. It was reported that the Clinical Governance Oversight Group, at their June 2024 meeting, approved a refreshed approach to the adverse event trigger list, which aligns with the Health Improvement Scotland framework. Ongoing challenges continue for the clinical teams for significant adverse event reviews (SAERs), and that once the adverse event trigger list is embedded, it is anticipated that volume of SAERs will reduce. Improvement plans for SAERs were also highlighted.

Further information was requested in relation to major adverse events in the category of 'Other'.

Action: Associate Director of Quality & Clinical Governance

In terms of inpatient falls, it was reported that the total for June 2024 was 203, which equates to a rate of 7.38 and exceeds the target, though remains within our control limits. It was noted that work is ongoing in relation to the Scottish Patient Safety Programme around the definition of a fall.

It was advised that work is ongoing around pressure ulcers, which was noted as being outwith the target. The majority of pressure ulcers are within Acute Services. It was also advised that the Tissue Viability Improvement Group are meeting regularly to discuss best practice. It was reported that organisational learning will be trialled as part of a cluster review across Acute Services.

The position for healthcare associated infections was highlighted, and following a question, it was advised that work is underway for a cluster review around infections, and the Director of Nursing agreed to provide an update, once available.

Action: Director of Nursing

The Interim Director of Health & Social Care provided an update on the mental health quality indicators and reported that a lot of work is being carried out to ensure that the ligature incident risks are minimised.

The Medical Director agreed to follow up on the Hospital Standardised Mortality Ration (HSMR) data, noting that the latest data within the report is from December 2023.

Action: Medical Director

The Committee took a **"moderate" level of assurance** from the performance data reported to the meeting.

9.2 Healthcare Associated Infection Report

The Director of Nursing spoke to the report and highlighted that the surgical site surveillance continues to be suspended nationally, and that some surgical site surveillance continues to be carried out locally. Assurance was provided that there are local systems and processes in place with regards to identification of surgical site inspection in the three surveillance categories. It was also highlighted that there have been no new inspections during the reporting period, and that a notice of a safe delivery of care inspection will commence in the maternity units in January 2025. The national cleaning services specification and estates monitoring position was highlighted as achieving green status.

An overview was provided on outbreaks, and it was noted that the ward closure position is normal for the reporting period. It was also noted that a cluster review was carried out the previous year for Staphylococcus aureus Bacteraemia (SABs), and that ongoing surveillance is carried out to prevent infections. Assurance was provided that NHS Fife has the lowest rate of SABs in Scotland.

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

9.3 Medical Devices Update

The Medical Director provided an update and advised that the paper provides detail in relation to NHS Fife's response to the requirements of a medical devices framework and policy. Due to the implementation of the UK Medical Device Regulations (UMDR), a robust governance process is required to be put in place and matters by exception will be reported to the Clinical Governance Committee. It was noted the regulatory framework from the UMDR is awaited, and that the foundations for good governance will be worked through, until the framework is in place.

The Associate Director of Quality & Clinical Governance reported that the Scan for Safety implementation date is September 2025, and that the focus of that work will be on orthopaedics, ophthalmology, interventional, radiology and cardiology. Patient information and supporting documentation will also be developed at that time.

The Deputy Medical Director provided an overview on accessing Scan for Safety and advised that a short-life working group is taking forward the recommendations. The completion date is early 2025, which NHS Fife is on track for, and a report will go to the Medical Devices Group and escalated appropriately.

Action: Medical Director

It was advised that any associated corporate risks will be considered through the various governance routes.

The Committee took 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.

9.4 Organisational Learning Update

The Associate Director of Quality & Clinical Governance noted that a recent Board Development Session was held on organisational learning, and that the update documents progress to date, including feedback received from the session. It was noted that next steps are being considered through the Organisation Learning Leadership Group. It was confirmed that membership of the group has recently been reviewed and includes a digital representative.

The Chair requested that all health settings are referred to as 'Point of Care to Board', as opposed to 'Ward to Board', to ensure we include all healthcare settings.

Action: Associate Director of Quality & Clinical Governance

The Committee took a **"moderate" level of assurance**, with 2024/25 being used as the year to focus on laying foundations on which to build upon this work.

9.5 Deteriorating Patient Improvement Programme

The Chair welcomed Gavin Simpson, Anaesthetics Consultant, to the meeting, who spoke to the paper. It was advised that the deteriorating patient improvement programme is to build a safety net across the Health & Social Care Partnership and Acute Services Division for deteriorating patients through maintaining standards and processes to a high degree of quality that can detect, communicate and escalate deteriorating patients, should they continue to be unwell.

Background detail was provided on the increase in cardiac arrests, and an overview was provided on the analysis that has been carried out and improvement work, which is detailed within the paper. It was noted that performance is being regularly measured, and that a structured framework will provide a focus on improvement work over the next 12 months.

J Bennett, Non-Executive Member, requested the inclusion of the measurement framework in the next update to Committee and also requested further detail on the data for cardiac arrests. It was agreed this would be progressed outwith the meeting.

Action: Associate Director of Quality & Clinical Governance

The Committee took a **"moderate" level of assurance** and **supported** the continued focus on this work for the remainder of 2024/25 and for 2025/26.

9.6 Neonatal Mortality Review Health Improvement Scotland (HIS) Report

The Medical Director advised that, in 2022, the Minister for Public Health, Women's Health and Sport commissioned HIS to take forward a review in response to this significant increase in neonatal mortality. It was advised that the report details our response to the HIS report and the main findings of the national review were outlined. It was noted that the improvement plan is currently being considered by the Acute Clinical Governance Committee.

Clarity was provided that there is a standardised reporting method for neonatal deaths. It was advised that there were initially some inconsistencies within the proforma. Assurance was provided that adverse event reviews are extremely detailed.

An explanation was provided on the quality controls for grading outcomes, with it being noted that there are debates from staff around determining the correct level, particularly the higher level gradings. Assurance was provided that the Medical Director, Director of Nursing and Acting Director of Pharmacy review the proformas for consistency.

It was advised that a draft plan is being worked through for the 'Best Start Programme for Scotland', and an update will be brought to the Committee in due course.

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

10. DIGITAL / INFORMATION

10.1 Digital and Information Strategy 2019-24 Update

The Director of Digital & Information reported that the update details the agreement to delay the refresh of the five-year digital strategy and move to a short-term digital framework, which has been agreed by the Digital Information Board and also has formed part of the corporate objectives for this year. It was advised that the short-term framework has a focus around the Reform, Transform, Perform (RTP) programme of work and is also aligned to the medium-term financial plan. Suggestion was made to extend the duration of the strategy, alongside having the new framework. It was noted that the RTP strategy has a number of underpinning frameworks, including Digital & Information.

It was further reported that the change to the strategy was due to a new Scottish Government model of governance being established, and it was advised that Board Chief Executives are shortly meeting to consider the Blueprint for NHS Scotland Digital.

An overview was provided on the features from the short-term framework that sit within the associated digital & information corporate risk.

It was confirmed that the newly launched Health & Social Care Partnership Digital Strategy has been referenced within the new short-term framework in terms of planning and associated deliverables.

The Chief Executive provided the rationale for moving from a refreshed strategy to a framework, with the aim of having one NHS Fife strategy with associated frameworks with priorities for delivery. It was agreed a summary regarding the 2019-2024 strategy would be provided to the NHS Fife Board at its next meeting, to record the completion of this part of the work.

Action: Director of Digital & Information

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

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

The Medical Director explained that the HEMPA programme has been renamed to Digital Medicines Programme, as it encompasses three distinct areas: HEMPA, pharmacy stock control system, and electronic discharge documents. Supplier and delivery issues were highlighted, and it was noted that there is an impact on staff due to delays.

The Acting Director of Pharmacy & Medicine outlined the challenges from the supplier of the pharmacy stock control system, advising that a 'go live' date is likely to be February 2025. It was noted that there are risks to this, which are currently being worked through.

The Committee took a **"limited" level of assurance** in terms of the supplier and their ability to delivery by the stated timeframe. The Committee took a **"significant" level of assurance** of the actions by NHS Fife staff, digital pharmacy and medicines medical teams to support this.

10.3 Information Governance & Security Steering Group Update

The Director of Digital & Information provided an update and advised that the Information Governance & Security Steering Group accountability and assurance framework is presented on a quarterly basis to the steering group, and that this work aligns to the Information Commissioner's Office audit and our commitment to the public sector cyber assurance framework, which is audited through the NHS Education for Scotland audit on an annual basis. An improved outcome for this year's audit was highlighted.

An overview was provided on the key priorities, which are aligned to the current risk profile, and include policy & procedure alignment, continued development of training and awareness for issues around information governance & security records management. The Director of Digital & Information agreed to provide more explicit detail, in terms of level of activity, for any escalations from the Information Governance & Security Steering Group and reports to the Committee.

Action: Director of Digital & Information

Following a question, it was confirmed that performance measures are in relation to technical controls.

The Committee **noted** the progress being made across the Information Governance and Security domains and took a **"moderate level of assurance"** from the governance, controls and improvement plans in place.

10.4 St Andrews Community Hospital Security Breach Update & Action Plan

The Director of Digital & Information provided background detail on the security breach at St Andrews, and the detail of the learnings from the incident are provided in the paper, along with the action plan.

It was advised that training compliance is regularly audited through various governance routes, and that NHS Fife currently comply with the information governance & security mandatory training, which is a three-year cycle. It was also advised that the work of the Information Governance & Security Steering Group is focussed on providing opportunities for individual learning.

The Director of Nursing highlighted the importance of checking staff identification to limit the risks of a similar incident occurring.

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

11. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

11.1 Patient Story

Due to time constraints at the meeting, the presentation slides were circulated to the Committee, with comments/feedback welcomed.

11.2 Patient Experience & Feedback

The Director of Nursing advised that patient complaints now form part of the monthly Integrated Performance & Quality Report. In terms of stage two complaints, it was reported that clinical pressures continue to impact on the ability to respond within key timeframes and that work is ongoing to look at solutions for early direct dialogue with complainants. It was noted that there is a lot of positive work being undertaken.

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

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

The Director of Nursing advised that the Patient Rights Annual Report will be presented to the NHS Fife Board at their September 2024 meeting, before it is published.

It was agreed to hold a Development Session on The Patient Rights Directions.

Action: Director of Nursing / Board Committee Support Officer

The Committee took a **"significant" level of assurance** from the report and **"endorsed"** recommendation for NHS Fife Board approval.

12. PROFESSIONAL STANDARDS

12.1 Advanced Practitioners' Review Update

The Director of Nursing provided an overview and reported that currently there are 49 whole time equivalent Advanced Nurse Practitioners within the Acute Services Division, and 36 whole time equivalents within the Health & Social Care Partnership. The challenges for protected non-clinical time to support achievement of the four pillars were outlined. It was reported that, due to the complexities of the role, the Nursing & Midwifery Council will be approving recommendations to develop an approach to regulate advanced practice.

The Director of Nursing agreed to provide further information in relation to the insights regarding the challenges for continuous professional development. C Grieve, Non-Executive Member, offered to speak to the Director of Nursing outwith the meeting in relation to the Staff Governance aspects of the update.

Action: Director of Nursing

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

12.2 Allied Health Professional Assurance Framework Update

The Director of Nursing noted that the Allied Health Professional Assurance framework will also be presented to the Staff Governance Committee.

The Director of Nursing agreed to provide further detail in future reports, reflective of that provided within the Allied Health Professionals framework. It was noted that this would strengthen assurance to the Committee, whilst acknowledging the ongoing challenges with provision of protected time

Action: Director of Nursing

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

13. ANNUAL REPORTS / OTHER REPORTS

13.1 Care Opinion Annual Report 2023/24

The Director of Nursing advised that the report provides positive detail on our performance for care opinion. A positive comment was made in relation to using volunteers to capture patient experience. The Chair requested a snapshot of the actions taken in response to care opinion.

Action: Director of Nursing

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

13.2 Controlled Drug Accountable Officer Annual Report 2023/24

The Acting Director of Pharmacy & Medicines advised that the report outlines the actions that have been undertaken over the previous year and demonstrates the significant and extensive work that has been carried out across the whole system, with a multidisciplinary approach, to ensure that controlled medicines are used safely and securely.

The governance routes were outlined, and it was highlighted that comprehensive assurance assessments are undertaken every six months across 100 clinical areas that hold controlled medicines, with action plans developed for areas of improvement,

along with training and resources to support staff. It was confirmed that progress of action plans is monitored on a biannual basis, and that there is oversight via the various governance routes.

An overview was provided on the incident data, with it being noted that any instances that are graded as major undergo a significant adverse event review.

It was reported that an organisational action plan has been developed over the previous year, and focuses on attractive drugs, which are at risk of diversion. It was also reported that a monthly review of the dashboard is undertaken on a monthly basis to identify any themes or areas for concern.

In terms of the quality & safety of prescribing for patients, it was confirmed that this work is overseen through our High Risk Pain Medicine Safety Group.

The Committee took a **"significant" level of assurance** with regard to fulfilment of the responsibilities of the Controlled Drug Accountable Officer.

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

The Director of Nursing provided background detail to the report, noting that this is the second annual report being presented to the Committee.

It was confirmed that a local action plan and recommendations are being taken forward through the Child Death Oversight Panel, and, at their previous meeting, a request was made to refresh the action plan. Discussion took place around the complexities of multi-agency work in sensitive areas such as this.

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

11. LINKED COMMITTEE MINUTES

The Committee **noted** the linked committee minutes and also **noted** that there were no escalations to the Committee from any of these minutes.

11.1 Area Clinical Forum held on 1 August 2024 (unconfirmed)

11.2 Area Medical Committee held on 11 June 2024 (confirmed)

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

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

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

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

11.7 Infection Control Committee held on 7 August 2024 (unconfirmed)

11.8 Medical Devices held on 12 June 2024 (unconfirmed)

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

11.10 Resilience Forum held on 13 June 2024 (unconfirmed)

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

There were no matters to escalate to NHS Fife Board.

13. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 25 SEPTEMBER 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 1 November 2024 from 10am – 1pm via MS Teams

Meeting: **Clinical Governance Committee**

Meeting date: **6 September 2024**

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

1. Committee's Performance against Annual Workplan

The Committee reviewed the workplan for the financial year 2024/25.

The following items have been deferred and rescheduled:

- Director of Public Health Annual Report 2024 – deferred to November 2024
- Occupational Health Annual Report 2023/24 – deferred to January 2025

The following items have been added to the workplan with planned dates to provide assurance relating to quality and safety impacts of performance:

- Cancer Waiting Times risk
- Access to outpatient, diagnostic and treatment risk
- Whole System Capacity risk

2. Matters Arising

2.1 Reinforced Autoclaved Concrete

An update was provided on the detail of the final survey results undertaken to identify Reinforced Autoclaved Aerated Concrete (RAAC) within the NHS Fife estate. It was highlighted that two additional areas, one at Adamson Hospital and one at Glenrothes Hospital, have now been identified as containing RAAC, since the previous report, and assurance was provided that there is no immediate risk to patients, staff or visitors. Moderate Assurance.

2.2 Alcohol and Drug Related Deaths Review Processes

A briefing paper was provided on the processes in place to review Alcohol and Drug related Deaths in Fife, It was agreed a further paper will be provided to the Committee at the November 2024 meeting relating to the learning from the reviews and associated improvement work. Moderate Assurance.

2.3 RTP: Acute Services Redesign Programme Phase 1

The Committee took a "moderate" level of assurance in relation to Phase 1 of the Acute Service Redesign Programme and endorsed the programme from a quality & safety perspective. The Committee noted the initial three priority areas: 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.

3. The Committee considered the following items of business:

3.1 GOVERNANCE

3.1.1 Clinical Governance Oversight Group Assurance Summary

The report was discussed, and the Scottish Hip Fracture Standards in Fife noted in particular the standard relating to time to theatre. It was advised that an update and an improvement plan will come to the Clinical Governance Committee in November 2024, and that the output for the hip fracture audit work will also come forward in due course. Assurance was provided that a review has been completed on trauma services within NHS Fife, and that improvement options are being worked through.

3.1.2 Corporate Risks Aligned to CGC

There are 5 corporate risks aligned to the CGC. There are no new risks.

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.

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, it was agreed that a mapping exercise of the current risks aligned to the committee, the risk mitigations and gaps, with a report back to the Committee in November 2024.

No.	Risk	Actions Required
5	Optimal Clinical Outcomes	Risk currently being revised
9	Quality and Safety	Organisational Learning Plan
6	Off Site Area Sterilisation and Disinfection Unit Service	Endorsed recommendation to NHS Fife Board to remove from corporate risk register to operational risk
17	Cyber Resilience	No change
18	Digital and Information	No change

3.2 STRATEGY AND PLANNING

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

The Committee endorsed submission of the Quarter 1 update and response to Annual Delivery Plan feedback to Scottish Government and took a “moderate” level of assurance from the report.

3.3 QUALITY AND PERFORMANCE

3.3.1 IPQR

The IPQR was reviewed and discussed; there were no performance related issues for escalation to the Board. Information to be provided to next CGC regarding major extreme adverse events categorised as other. Noted the latest Hospital Standardised Mortality Ratio (HSMR) data, will be provided at the next meeting.

3.3.2 HAIRT

The HAIRT report was reviewed and discussed. There were no infection and prevention control issues for escalation to the Board. Assurance was provided that there are local systems and processes in place with regards to identification of surgical site inspection in the three surveillance categories. Noted no new inspections during the reporting period, and that a notice of a safe delivery of care inspection will commence in the maternity units in January 2025. Assurance also provided that NHS Fife has the lowest rate of SABs in Scotland.

3.3.3 Medical Devices Update

The Committee took a “moderate” level of assurance from the paper noting the robust governance processes in place. Noted that a Short Life Working Group is taking forward recommendations for Scan for Safety, which has a completion date of early 2025. NHS Fife is on track a report will go to the Medical Devices Group and escalated appropriately.

3.3.4 Organisational Learning Update

The Committee took a “moderate” level of assurance, with 2024/25 being used as the year to focus on laying foundations on which to build upon this work. Noted that membership of the group has recently been reviewed and includes a digital representative.

3.3.5 Deteriorating Patient Improvement Programme

The Committee took a “moderate” level of assurance and supported the continued focus on this work for the remainder of 2024/25 and for 2025/26. Noted that performance is being regularly measured, and that a structured framework will provide a focus on improvement work over the next 12 months.

3.3.6 Neonatal Mortality Review Health Improvement Scotland (HIS) Report

The Committee took a “moderate” level of assurance from the report. The report details our response to the HIS report and an improvement plan is currently being considered by the Acute Clinical Governance Committee. Noted a draft plan is being worked through for the ‘Best Start Programme for Scotland’ and an update will be brought to the Committee in due course.

3.3.7 Digital & Information

The Committee took a “moderate” level of assurance from the update. It was reported that the Digital Information Board have agreed to delay the refresh of the five-year digital strategy and move to a short-term digital framework, which has formed part of the corporate objectives for this year. The short-term framework has a focus around the Reform, Transform, Perform (RTP) programme of work and is also aligned to the medium-term financial plan.

3.3.8 Digital Medicines Programme (HEPMA)

The Committee took a “limited” level of assurance in terms of the supplier and their ability to deliver the programme within by the agreed timeframe. The Committee took a “significant” level of assurance of the actions by NHS Fife staff, digital pharmacy and medicines medical teams to support this programme.

3.3.9 Information Governance & Security Steering Group Update

The Committee noted the progress being made across the Information Governance and Security domains and took a “moderate level of assurance” from the governance, controls and improvement plans in place. The Information Governance & Security Steering Group accountability and assurance framework is presented on a quarterly basis to the steering group, and the work aligns to the Information Commissioner's Office audit and our commitment to the public sector cyber assurance framework, which is audited through the NHS Education for Scotland audit on an annual basis. An improved outcome for this year’s audit was highlighted.

3.3.10 St Andrews Community Hospital Security Breach Update & Action Plan

The Committee took a “moderate” level of assurance from the update. Noted that training compliance is regularly audited through various governance routes, and that NHS Fife currently comply with the information governance & security mandatory training, which is a three-year cycle. Also noted that the work of the Information Governance & Security Steering Group is focussed on providing opportunities for individual learning.

4. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

4.1 Patient Experience & Feedback

The Committee took a “limited” level of assurance from the report. Noted that clinical pressures continue to impact on the ability to respond within key timeframes to stage 2 complaints, and that work is ongoing to look at solutions for early direct dialogue with complainants. Noted that there is a lot of positive work being undertaken.

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

The Committee agreed to hold a Development Session on The Patient Rights Directions.

5. PROFESSIONAL STANDARDS

5.1 Advanced Practitioners Review Update

The Committee took a "limited" level of assurance from the update. The Director of Nursing agreed to provide further information in future reports to strengthen assurance

5.2 Allied Health Professional Assurance Framework Update

The committee commended the report taking a significant level of assurance from the framework.

6. ANNUAL /OTHER REPORTS

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

- Care Opinion Annual Report 2023/24 (moderate level of assurance)
- Controlled Drug Accountable Officer Annual Report 2023/24 (significant level of assurance)
- Review of Deaths of Children & Young People Annual Report 2023/24 (significant level of assurance)

7. Delegated Decisions Taken by The Committee

Nil to report.

8. 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
- 'Off-Site Area Sterilisation and Disinfection Unit Service' risk recommended to remove this risk from the Corporate Risk Register
- Committee endorsed submission of the Quarter 1 update and response to Annual Delivery Plan feedback to Scottish Government
- There were three areas of limited assurance: HEPMA Programme; Complaints Handling, Advance Nurse Practitioners Review Update

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 1 November 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
1.	06/09/24	**Advanced Practitioners' Review Update**	To provide further information in relation to the insights regarding the challenges for continuous professional development.	**JK**		November 2024
2.	06/09/24	**Care Opinion Annual Report 2023/24**	To provide to the Chair, a snapshot of the Care Opinion Annual Report 2023/24.	**JK**		November 2024
3.	06/09/24	**Integrated Performance & Quality Report**	To provide an update on the cluster review that is underway, once available.	**JK**		Once available
4.	06/09/24	**Allied Health Professional Assurance Framework Update**	To provide further detail in future reports, reflective of that provided within the Allied Health Professionals framework.	**JK**	Closed.	Future reports
5.	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**	Closed. Committee agreed at the September 2024 meeting that the RAG status for numbers of adverse events is removed.	September 2024
6.	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**	Closed.	September 2024
7.	06/09/24		To follow up on the Hospital Standardised Mortality Ration (HSMR) data, as the latest data within the report is from December 2023.	**CM**	Closed.	November 2024
8.	06/09/24	**Off-Site Area Sterilisation and Disinfection Unit Service Risk**	To recommend to the NHS Fife Board for the removal of the 'Off-Site Area Sterilisation and Disinfection Unit Service' risk from the Corporate Risk Register to be tracked instead as an operational risk.	**CM**	Closed.	September 2024

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 1 November 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
9.	12/01/24	**Medical Appraisal and Revalidation Annual Report 2022/23**	To provide narrative around performance for revalidation, in the next report.	**CM**	Closed. On agenda.	November 2024
10.	12/07/24	**Integrated Performance & Quality Report**	To provide further detail around mental health incidents in terms of the most common themes.	**FM**	Closed. FM discussed with J Torrance.	November 2024
11.	06/09/24	**Digital and Information Strategy 2019-24 Update**	A summary regarding the 2019-2024 strategy to be provided to the NHS Fife Board at its next meeting, to record the completion of this part of the work.	**AG**	Closed. On agenda - closure report for the Digital Strategy 2019-2024 will go to the November CGC, and the same report will go to the Board in November.	November 2024
12.	06/09/24	**The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions**	To hold a Development Session on The Patient Rights Directions.	**JK/HT**	Closed. Arranged for 22 November 2024.	November 2024
13.	06/09/24	**Information Governance & Security Steering Group Update**	To provide more explicit detail, in terms of level of activity, for any escalations from the Information Governance & Security Steering Group and reports to the Committee.	**AG**	Closed. Updated issued.	November 2024
14.	06/09/24	**Integrated Performance & Quality Report**	Further information to be provided in relation to major adverse events in the category of 'Other'.	**GC**	Closed. Now included in IPQR with work agreed at CGOG to replace this category with more specific subcategories.	November 2024
15.	06/09/24	**Organisational Learning Update**	All health settings to be referred to as ‘Point of Care to Board’, as opposed to ‘Ward to Board’, to ensure we include all healthcare settings.	**GC**	Closed. Noted and will be included in ongoing work	November 2024

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 1 November 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
16.	06/09/24	**Clinical Optimal Outcomes Risk**	A revised Optimal Clinical Outcomes risk be brought back to the Committee in November 2024.	**CM**	Closed. Work is ongoing between the Medical Director and the Associate Director of Risk and Professional Standards. Plan to replace the current risk and strengthen clinical risk profile of the operational performance risks aligned to FPR.	November 2024
17.	06/09/24	**Corporate Risks Aligned to Clinical Governance Committee**	To take forward a mapping exercise in terms of the risks aligned to the Clinical Governance Committee, what is being measured and any gaps.	**CM**		January 2025
18.	06/09/24	**Briefing Paper: Alcohol and Drug Death Reviews in Fife**	To provide a further paper to the Committee around the improvements and measures for cluster reviews.	**CM**	Closed. Adverse Events paper on the agenda.	November 2024
19.	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**	Closed. 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.	November 2024
20.	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**	Closed. The Acute Services Redesign Programme to report via the Clinical Governance Committee, with the first report on the agenda for the September 2024 meeting.	November 2024

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 1 November 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
21.	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**	Closed. On agenda.	November 2024
22.	06/09/24	**Medical Devices Update**	A report on Scan for Safety to be provided to the Medical Devices Group, and escalate as appropriately, once the SLWG has taken forward the recommendations.	**CM**	Removed. Not an action for CGC.	Early 2025
23.	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**	Closed. Corporate Risk Register not scheduled to be considered by the Board until November 2024.	26 November 2024
24.	06/09/24	**Deteriorating Patient Improvement Programme**	The inclusion of the measurement framework to be included in the next update to Committee and further detail on the data for cardiac arrests.	**GC**	Closed.	January 2024

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**East Region Neonatal Services Update**
Responsible Executive:	**Claire Dobson, Director of Acute Services**
Report Author:	**Aileen Lawrie, Director of Midwifery**

Executive Summary:

- The Minister for Public Health and Women's Health announced on 25 July 2023 the new model of neonatal care for Scotland.

- Care for babies born at less than 27 weeks, lighter than 800 grams or who are critically ill will have care provided by Neonatal Intensive Care Units (NICU) under a new networked model at Aberdeen Maternity Unit, (AMU) Edinburgh Royal Infirmary (ERI) and Queen Elizabeth University Hospital (QUEH).

- The declared capacity for NHS Fife within the RSM Report is incorrect. Our declared cot capacity is 17 cots and RSM have conducted the modelling assumptions based on 20 cots, meaning the data is flawed.

- The change in cot capacity suggested by RSM will increase the numbers of in-utero and ex-utero transfers out with NHS Fife, previously highlighted within the Best Start Report.

- The recommendation of a 0.5 Intensive Care Cot (ICU) capacity will impact negatively on the ability of NHS Fife to care for women with multiple pregnancy, pre-term pregnancy and complex pregnancy.

- The proposed decrease in cots will impact on NHS Fife ability to repatriate babies back to the unit, resulting in the separation of mothers and babies.

1 Purpose

This report is presented for:

- Discussion

This report relates to:

- Emerging issue.
- Government policy/directive.
- National Health & Wellbeing Outcomes/Care & Wellbeing Portfolio.
- - NHS Board Strategic Priorities to Improve Health & Wellbeing.
  - To Improve Quality of Health & Care Services.
  - To Improve Staff Experience & Wellbeing.
  - To Deliver Value & Sustainability.

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

- Safe,
- Effective,
- Person Centred.

2 Report summary

2.1 Situation

This paper provides limited assurance in relation to the recommendations of the Scottish Government commissioned consultancy led Neonatal Unit Redesign. If implemented the recommendations would have a significant and negative impact on Fife patients with a proposed reduction in cots which would impact on NHS Fife's ability to repatriate babies, resulting in the separation of mothers and babies as well as significant workforce impacts.

2.2 Background

The Minister for Public Health and Women's Health announced on 25 July 2023 the new model of neonatal care for Scotland. This means that care for babies born at less than 27 weeks, lighter than 800 grams or who are critically ill will have care provided by Neonatal Intensive Care Units (NICU) under a new networked model at Aberdeen Maternity Unit, (AMU) Edinburgh Royal Infirmary (ERI) and Queen Elizabeth University Hospital (QUEH).

NHS Fife was asked to be a "pathfinder" Board for the new model in 2019. After successful adaptation to the pathways for extreme pre-term infants, NHS Fife was allocated the status of a Local Neonatal Unit (LNU), which maintained delivery of both High Dependency (HDU) and Intensive Care (ICU) neonatal care for the Fife population.

NHS Fife participated in a meeting with the East Region planning group for the new model of neonatal care redesign (Best Start 2017) on 19 June 24. The meeting focus was to discuss the cot modelling outlined within the RSM report (Appendix 1). NHS Fife outlined concerns regarding the proposed model of cots at subsequent meetings with the East Region Re-Design Group.

Key Messages

The main highlights of the report:

- The declared capacity for NHS Fife within the RSM Report is incorrect. Our declared cot capacity is 17 cots and RSM have conducted the modelling assumptions based on 20 cots, meaning the data is flawed.

- The change in cot capacity suggested by RSM will increase the numbers of in-utero and ex-utero transfers outwith NHS Fife, previously highlighted within the Best Start Report.

- The recommendation of a 0.5 Intensive Care Cot (ICU) capacity will impact negatively on the ability of NHS Fife to care for women with multiple pregnancy, pre-term pregnancy and complex pregnancy.

- The proposed decrease in cots will impact on NHS Fife ability to repatriate babies back to the unit, resulting in separation of mothers and babies.

- The report does acknowledge that the impact on in-utero transfers, bed capacity and midwifery resource require further review, using the prospective dataset to understand the full system service redesign as the current data available is insufficient.

- RSM recommend Fife reduce total neonatal cot capacity to 10 cots, with the 0.5 ICU cot capacity included in this number. There is also a recommended configuration change with a reduction of SC cots to just under half the current configuration (6.6 cots), and an increase in HD of 1.5 cots. This modelling does not factor in the repatriation of babies who currently return to Fife requiring ICU and HD care. Local assessment suggests that should the new, reduced cot configurations be implemented, the Fife Neonatal Service will have insufficient capacity to meet demand for all levels of neonatal care for both in-born infants and those being repatriated from the tertiary centres.

2.3 Assessment

As a team we wish to highlight our concerns regarding the recommended reduction of total cot numbers and the loss of intensive care capability for NHS Fife in respect of the negative impact this will have on patient safety, morbidity and mortality, and patient and staff experience.

We have reviewed the same dataset as RSM against our locally held data and have identified that if we reduce to 10 cots, we will regularly be unable to meet the current capacity demands.

YEAR	No Days >10 Babies Admitted	No Days $\geq$ 1 ICU Admitted
2019	158	195
2020	102	175
2021	157	211
2022	201	220
2023	153	158
2024	*121	*81

*January-May 2024

The recommendation to reduce from the current 4 ICU cot capacity to 0.5 will not allow us to function as a Local Neonatal Unit (LNU), outlined within the Best Start Model as the ability to interprovide specialised and high dependency care, including assisted ventilation and short-term neonatal intensive care, and will impact negatively on our ability to care for women experiencing multiple, complex and late-premature births. The recommendation will mean we will not be able to provide intensive or high dependency care for late-preterm and sick neonates outwith Best Start transfer criteria, and will negatively impact on our ability to repatriate babies back to our Unit as we will not be able to fulfil the requirement to provide ongoing intensive care for up to 24 hours or longer term high dependency care.

Repatriation Criteria:

>= 27 weeks corrected gestational age
>= 800g

Respiratory support:

- Intubated, stable, extubation predicted within 24hours.
- Or non-invasive ventilation.
- Or support/low flow.

Fluids/feeding:

>= 50% of fluids given enterally (data suggests not fully achieved as yet).
No IV drug infusion.
Not predicted to require specialist intervention

If we model on the RSM cot and ICU recommended capacity, there would be over 100 women between 26 and 34 weeks gestation annually who would require in-utero transfer outwith NHS Fife (Appendix 2). This is an underestimate of numbers as we cannot obtain actual data for women who we currently admit but do not go on to birth their babies. The working assumption within the RSM Report is that for every 10 actual neonatal admissions, there will be 6 maternal admissions. Using this assumption would mean that an additional 60 maternal admissions would require transfer outwith Fife. In total over 160 women would require transfer out of NHS Fife annually. There are inherent risks to both a mother and fetus associated with in-utero transfer.

This report provides the following Level of Assurance regarding the RSM recommendations:

	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

Available research suggests consolidation of care to Tertiary Units improves outcomes for the smallest and sickest babies. NHS Fife have recognised this and successfully implemented this model of care since 2019. The move to reduce cot capacity will result in a cohort of women outwith these recommendations requiring to be transferred out of Fife. This will create an inequitable service for Fife families who will no longer be able to be cared for within their home Board. There is no recognition within the RSM report of the wider impacts on families already subject to the challenges of deprivation, e.g. travel and sustenance costs, childcare costs, separation of mothers and babies.

National Reports and the most recent MBRRACE Report highlight that NHS Fife maternity and neonatal service is safe and of high quality where morbidity and mortality as well as neuro developmental outcomes, and is highlighted as better than other comparable Units UK wide.

2.3.2 Workforce

There is concern that if we reduce to a 10 cot capacity there will be a need to undertake organisational change processes for the nursing team within the NNU as we would be overstaffed for a 10 cot unit. This will have detrimental effects on the team both as individuals and as a group, alongside a detrimental effect on NHS Fife's reputation as an exemplar employer. There will be the need to maintain the current medical staff establishment in order to cover the on-call and overnight commitment. The change in grading of the Unit to a Special Care Unit would have a detrimental effect on medical recruitment to both the neonatal and paediatric medical nursing vacancies.

2.3.3 Financial

A reduction in cot capacity will not lead to any financial saving for NHS Fife. No reduction in neonatal medical staff would be possible due to the requirement to maintain 24-hour cover of the remaining cots. No savings would be realised through reduction in clinical support roles, e.g. neonatal outreach, infant feeding support, clinical education roles. The same number of such staff would be required for a 10 cot unit as a 17 cot unit. Neonatal nursing staff would require to be redeployed and there would be a need to increase midwifery staffing to enable the number of in-utero transfers outlined. For every in-utero transfer, one midwife is required for transfer and 2 for multiple pregnancy transfers. If cots are reduced women who present with complex risk factors will also require to be transferred to a Maternity Service co-coated with a Level 3 NNU. We do not have data to accurately assess this impact. Looking at available data this would equate to a minimum of one transfer per week. This would need to be factored into workforce modelling.

2.3.4 Risk Assessment / Management

The risk of this proposed reduction in cot capacity would be the impact on the women, babies and families of Fife. Recent cot locator data shows that capacity within the tertiary units is limited, particularly in east and west Scotland. This means that there is the risk that a timely transfer of women would not be undertaken and/or Fife women would require to be transferred to Grampian.

The increased travel time may impact the safety of the woman and the unborn. Feedback from families subject to this model highlight:

- Lack of accommodation for families to be near their baby, resulting in immediate financial cost or mother/baby separation.

- Separation from family members and siblings with resulting childcare challenges/costs.
- Reduction in breastfeeding.
- Increase in complaints regarding differing care provision when being subject to cross boundary care.

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

The British Association of Perinatal Medicine (BAPM) outlines that each peri-natal network area should estimate their population's needs in terms of neonatal care. This estimate should be reviewed at least every 3 years. The need for service provision should take into account a variety of local factors such as the size and distribution of the population and the extent of any areas of deprivation.

As outlined in Fife Strategic Assessment 2024, child poverty in Fife continues to track just above Scotland (a proxy for household poverty). 23.6% of children in Fife are now living in relative poverty (in households with an income of less than 60% of UK median income 11) compared to 21.3% for Scotland (DWP, FYE 2023). This is broadly consistent with income and employment deprivation (SIMD 2020). As at February 2024, there were an estimated 31,285 low income households in Fife (LIFT dashboard). Single households are the largest group, accounting for two thirds of all low income households, 89% of whom are in a cash shortfall (expected take-home income less than expected expenditure). Lone parents are the second largest group (17.5%), followed by couples without children (9.8%). Couples with children account for 5.1% of low income households. Health inequalities during pregnancy, birth and early years can have a significant bearing on a child's development and their lifelong health, happiness and productivity in society. As part of the RSM modelling report, these factors are not reported. RSM have not undertaken an equality impact assessment within the report recommendations.

2.3.6 Climate Emergency & Sustainability Impact

There will be increased ambulance/Scotstar transfers. There will be increased travel requirements for families.

2.3.7 Communication, Involvement, Engagement and Consultation

NHS Fife highlighted concerns at the East Region meeting of 19 June 24 regarding the outlined public engagement strategy, with particular reference to inclusion and equity of access to the consultation.

2.3.8 Route to the Meeting

- Acute SLT 24 September 2024.
- Acute Services Division Clinical Governance Committee 25th September 2024
- EDG 3rd October 2024

2.4 Recommendation

This paper is provided to members for:

- **Discussion** – the paper is brought to the committee for discussion and awareness in particular that NHS Fife should maintain the status quo in terms of current capacity and

cot designation until spring 2025 and should NHS Fife be assured of the capacity to accept transfers out, decreasing to 15 total cots, 3 of which would be ICU could be considered.

3 List of appendices

- Appendix 1 - Capacity, Modelling, NICU Services Final Report

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Demand and capacity modelling of NICU services - Final Report

May 2024

Scottish Government
Riaghaltas na h-Alba

Executive Summary

Introduction and Aims

In 2017, the Scottish Government published 'The Best Start : A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland'. The Best Start outlined a new model of neonatal service provision that suggests that care for the smallest and sickest babies should be consolidated to deliver the best possible outcomes. The plan emphasises parents as key partners in caring for their babies and aspires to keep mothers and babies together as far as possible, with services designed around them.

The implementation of the new model includes:

- Consolidation of neonatal intensive care unit (NICU) services into three designated NICUs for Scotland for pre-term, very low birth weight, and critically ill babies, based on evidence to support better outcomes.
- A new networked model of three NICUs working alongside local neonatal units (LNUs) and special care units (SCUs), supported by transitional and community care services; and
- Leveraging lessons learnt from successful transformation of neonatal services across the rest of the UK.

An important part of planning for the implementation stage of the model of care is the modelling of demand and capacity requirements. This report outlines this modelling approach, inputs, and interpretation of the outputs to support the future of NICU services. This aligns with the Best Start recommendations and focuses on the three regional NICU sites chosen for adoption in Scotland. To further support local implementation plans, this report also outlines a series of considerations for implementation that can be taken forward beyond this commission.

Approach

The approach to this work has included data collection and modelling alongside engagement with both operational and strategic stakeholders, to validate data, generate and test planning assumptions. Activity and capacity data was collected from each of the eight units included within the model scope, as well as Public Health Scotland (PHS) and Scottish Specialist Transport and Retrieval (ScotSTAR) / Scottish Ambulance Service (SAS).

The baseline data period is October 2022 to September 2023, and the model planning horizon is 2026/27[1]. A series of change assumptions have been identified for inclusion in the model, including the process for identifying the smallest and sickest babies who will move in the future model of care, principles for the flow of babies between neonatal units, and operational assumptions to help predict the impact of changes on Neonatal and wider services.

[1] Note with the exception of University Hospital Wishaw, see 3.1.1.

High level findings and conclusions

Table A includes a breakdown of:

- Declared capacity (current available physical cot capacity, irrespective of utilisation / staffing).
- Baseline capacity requirement (capacity required to accommodate baseline activity levels); and
- Projected capacity requirement (the final predicted capacity required to meet activity to 2026/27, given the modelled flow of babies into and out of each unit).

For implementation planning a meaningful comparison can be made between baseline and projected capacity requirements, as these are both measures of the required staffed capacity to meet demand under the current and future model of care. A comparison against declared capacity is helpful in understanding any potential physical capacity constraints under the new model of care. Overall baseline capacity requirements are lower than current declared capacity (in total, by 23 cots across the eight units, with the biggest differences seen in early implementer sites where activity shifts are already reflected in baseline activity levels), future projection changes vary by site due to the flow of babies, with a small overall change due to a combination of population and incidence changes. The largest projected increase in required capacity for the new model of care is for Royal Hospital for Children, Glasgow, with an overall increase of approximately 12 cots. This requirement may be mitigated through the use of additional capacity for neonates requiring high dependency or special care in either of the two LNUs within the Glasgow and Greater Clyde Health Board. The Simpson Centre, Edinburgh, and Aberdeen Maternity Hospital are projected to see increases in demand and required capacity, though at a lower level. Decreases in required future capacity are predicted for other sites, with the largest decrease seen at Wishaw, predominantly in intensive care (IC) capacity, and an overall increase in special care cots which will support the timely repatriation of babies in the new model of care. The projected impact at both Victoria Hospital, Fife, and Crosshouse, Kilmarnock, is minimal - these sites are already early implementers of the new model of care, and as such they would not expect to see significant additional shifts in activity beyond that already reflected in the baseline period.

Table A: Summary projections, total of IC, HD, SC cot requirements

Site	**Declared Capacity** (total available physical capacity)	**Baseline Capacity** (Required for baseline activity)	**Projected Capacity Requirement** (final predicted capacity)
Aberdeen Maternity	34	28	29
Royal Hospital for Children	50	52	62
Simpson Centre	39	39	43
Ninewells	21	20	17
Princess Royal Maternity	28	24	20
University Hospital Wishaw	29	29	21
Victoria Hospital Fife	20	11	10
University Hospital Crosshouse	20	15	14

Implementation considerations

As a part of the engagement with operational and strategic stakeholders throughout the modelling process, a range of feedback has been provided, that will need to be considered during the implementation of the future national model of care. This has been captured and summarised into four key themes: Workforce; Capacity and occupancy; NICU flows and repatriation; and Implementation enablers. Each of these themes and implementation considerations has been shared and refined during the final set of workshops with stakeholders and will be for consideration of Scottish Government and Regional Planning teams to take forward. Based on feedback the most pressing need will be for detailed consideration of workforce requirements, with this area significantly interlinking with capacity and NICU flows.

Limitations

Due to the compressed timeframes available for data collection, there have been differences in extraction approaches across units and variability in the quality and coverage of data received. These limitations have been mitigated where possible and also validated with stakeholders. A full list of data limitations and assumptions made can be found in Annex A. The scope of this report excludes existing LNUs and SCUs in Scotland, under the assumption that activity in these units will not change under the new model. A full analysis of maternity capacity was also not included within the remit of this commission, but the additional demand on the three future NICU sites has been estimated. Workforce requirements have been excluded from this exercise and will form part of ongoing regional implementation planning work.

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1. Introduction

1.1 Background

RSM UK Consulting LLP, in collaboration with neonatologist Prof Neil Marlow and neonatal nurse advisor Doreen Crawford, were commissioned by the Scottish Government (on behalf of NHS Scotland) to undertake a demand and capacity modelling exercise for neonatal intensive care unit (NICU) services in Scotland.

Neonatal care in Scotland has been a key area of focus and improvement over the last decade. A Strategic Review of Maternity and Neonatal Services in Scotland was announced by the Minister for Public Health in early 2015. In 2017, the Scottish Government published 'The Best Start : A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland'. Within this transformational plan, the traditional models of healthcare provision were replaced by a family centred approach to care delivery and participation, decision making and service structure which have been shown to optimise infant outcomes.

For this ambitious plan to succeed, several changes need to occur, including:

- Redesigning service provision;
- Ensuring opportunities for education and training are available to deliver the new model and ensure competency;
- Undertaking workforce planning based on the new model;
- Improving care using information and communication technologies in clinical and non-clinical domains; and,
- Facilitating seamless transfer across the country and beyond.

The Best Start outlined a new model of neonatal service provision that suggests that care for the smallest and sickest babies should be consolidated to deliver the best possible outcomes. The implementation of the new model includes:

- Consolidation of NICU services into three designated NICUs for Scotland for pre-term, very low birth weight, and critically ill babies, based on evidence to support better outcomes;
- A new networked model of three NICUs working alongside local neonatal units (LNUs) and special care units (SCUs), supported by transitional and community care services; and
- Leveraging lessons learnt from successful transformation of neonatal services across the rest of the UK.

The plan emphasises parents as key partners in caring for their babies and aspires to keep mothers and babies together as far as possible, with services designed around them.

1.2 Purpose of this report

This report outlines the modelling approach, inputs, and interpretation of the outputs to support the future of NICU services. This aligns with the Best Start recommendations and focuses on the three regional NICU sites chosen for adoption in Scotland. This report also outlines a series of considerations for implementation that can be taken forward beyond this commission.

2. Methodology

2.1 Overarching approach

The scope of this work focuses on understanding the demand and physical capacity needs of the future model of neonatal care in Scotland. The approach to this work contains two main strands: modelling and engagement. Figure 1 below provides an illustrative overview of each stage, alongside the key modelling and engagement activities.

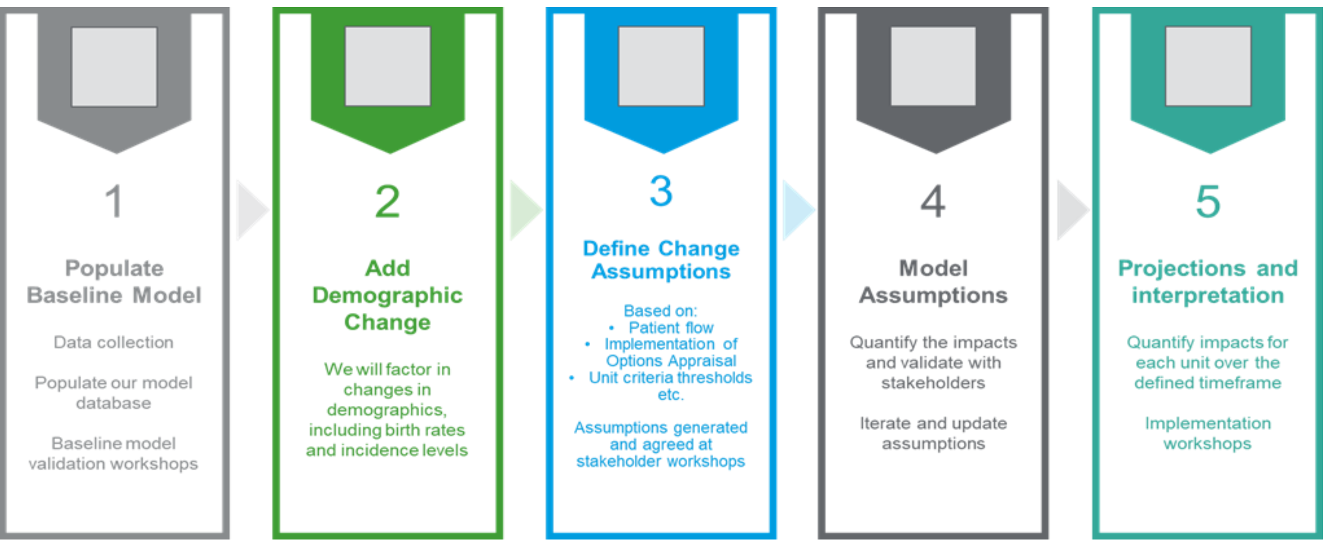
Figure 1 Diagram of Overarching approach

	Modelling	Engagement
Stage 0: Project inception and scoping	• Set out data specification • Review modelling approach • Desk review of project documentation	• Project inception meeting • Identity key contacts for data collation
Stage 1: Baseline	• Build baseline using local data • Data to include 12 months of activity, capacity (eg cots), workforce, pathway, outcome and case mix	• x3 Baseline workshops – with operational and strategic stakeholders • To validate baseline data and inform preliminary assumptions
Stage 2: Modelling impact	• Apply demographic change • Model change assumptions	• x3 Modelling Validation workshops – with operational and strategic stakeholders • To validate modelling assumptions
Stage 3: Projections and implementation	• Derive future demand and capacity requirements • Sensitivity analysis	• x3 Implementation workshops – with operational and strategic stakeholders • To review scenarios and inform implementation plans
Stage 4: Reporting	• Draft report on finalised demand and capacity model • Model handover	• Presentation of final demand and capacity model • Model handover

2.2 Approach to modelling

The modelling approach has encompassed five stages, as summarised in Figure 2.

Figure 2 Diagram of modelling approach



2.2.1 Populate Baseline Model

Data was collected from a range of sources (see Section 2.4 for more information) to develop the baseline analysis. Longitudinal analysis was conducted to determine whether there was any seasonality or time series trends in the data and to establish a baseline for the model. This baseline analysis was validated through a series of operational and strategic stakeholder workshops (see Section 2.5 for further information on engagement). Following the validation stage, the baseline data was used to develop the demand and capacity model.

2.2.2 Add Demographic Change

The first stage of the modelling was to apply demographic change to the model. This was applied using the Scottish sub-national 2018-based population projections (Source: ONS / National Records of Scotland) for each local authority area (applied to the place of residence to each mother in the baseline). Demographic change was modelled over the planning horizon (projected to 2026/27). Incidence rates for babies requiring NICU care was also applied, in line with feedback from stakeholders on the increased propensity to treat smaller and sicker babies over time.

2.2.3 Define Change Assumptions

Throughout the modelling and engagement with stakeholders, a series of change assumptions have been identified for inclusion in the model. These include:

- The process for identifying the smallest and sickest babies who will move in the future model of care;
- The principles for the flow of babies between neonatal units;
- The suggested occupancy rates across neonatal units and levels of care;
- The length of stay assumptions associated with the repatriation of babies to the future LNUs;
- The frequency of in-utero transfers, in relation to total activity; and
- Assumptions to help estimate the additional impact on maternity and transport services.

Sensitivity analysis (through alternative scenarios) has been undertaken to test for the impact of changing assumptions. The primary model assumptions for which alternative scenarios have been tested include:

- Changes in the proportions of sickest babies who would move in the future model; and
- The flow of babies between neonatal units.

2.2.4 Model Assumptions

The baseline data and assumptions have been used to model the following outputs:

- The future number of cots required at each of the in-scope units;
- The additional maternity capacity (in terms of maternity beds) required as a result of additional in-utero transfers; and
- The potential number of additional ex-utero transfers which will be required to support the future model of care.

The outputs of this modelling have been shared and validated with stakeholders through a range of operational and strategic stakeholder workshops. The interpretation of the modelled impacts has been included throughout Section 5 of this report.

2.3 Model scope

Table 1 provides a summary of the model scope[2], which was refined throughout initial engagement with Scottish Government, regional planners, and clinicians.

Table 1: Model scope

Identified NICU sites	• Neonatal Unit, Royal Hospital for Children, Glasgow (RHCG) • Aberdeen Maternity Hospital (AMH) • Simpson Centre for Reproductive Health, Edinburgh Royal Infirmary
Current NICU sites	• Ninewells, Dundee • Princess Royal Maternity, Glasgow (PRM) • University Hospital Wishaw, Lanarkshire (UHW)
Early implementer NICU sites	• University Hospital Crosshouse, Kilmarnock (UHC) • Victoria Hospital Kirkcaldy
Partner organisations	• ScotSTAR (babies) / Scottish Ambulance service • Regional planning partners • Scottish Perinatal Network • Public Health Scotland (PHS) • System C
In scope (for identified and previous NICU sites)	• National approach for the future model of care • Regional implications for future national model of care • Flow of babies between neonatal units (based on criteria thresholds) • Identification of smallest and sickest babies • Maternity capacity for babies transferred in utero • Capacity (cots) to support model of care • Repatriation of babies from NICU to other neonatal services (LNU/SCU)
Out of scope*	• Workforce to support model of care • Skills mix and safe staffing ratios • Training and CPD for neonatal staff

[2] It is important to note that detailed projections for workforce requirements have been moved out of scope for the modelling phase and will be addressed within the broader context of implementation considerations. These recommendations will inform the work of regional planners.

2.4 Summary of the evidence

In order to establish a baseline and evidence-based

2.4.1 Documentation reviewed

This modelling utilises and builds on a body of work that has going before it, not least 'The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland' (January 2017). This outlined the new model of neonatal service provision and changes that would need to occur to make this happen. In addition to this, the following key documentation was reviewed both for context and to support planning assumptions for the model:

- Neonatal Intensive Care Options Appraisal Report – A Five-Year Forward Plan for Maternity and Neonatal Services (July 2023)
- A Framework for Practice – Criteria to Define Levels of Neonatal Care including Repatriation within NHS Scotland (July 2023)
- Principles of Discharge Planning and Neonatal Follow Up, A Framework (November 2019)
- NHS Lothian Early Implementers Evaluation Report (November 2022)
- NHS Ayrshire and Arran Early Implementers Evaluation Report – (November 2022)
- Optimal Arrangements for Neonatal Intensive Care Units in the UK – A BAPM Framework for Practice (2021)

There was a range of publicly available supporting data that was used in the modelling approach, including population projections and geographical reference data.

2.4.2 Data requested

In order to have sufficient unit and geographical granularity within the baseline analysis and modelling, data was collected from PHS, ScotSTAR / Scottish Ambulance Service, plus each of the eight units that have been included within the model scope. The data collected was grouped into four thematic areas: activity, capacity, workforce, and patient cohort. Table 2 provides a summary of the data collected from each of these organisations.

Table 2 Summary of the data collected for modelling

	Data requested
Activity	Data was requested from units covering all neonatal activity for the previous three years. Information included within this dataset included: • Resident location of mother (postcode district / local authority) • Gestation • Birthweight • Factors to help identify the sickest babies • Number of cot days at each neonatal level of care (Intensive Care -IC, High Dependency -HD, Special Care -SC) The time period for this data request was October 2020 – September 2023
Capacity	Data was requested from units covering to identity trends in their capacity by neonatal level of care (IC, HD, SC) and for in-utero transfers. The following data was collected on a monthly basis:. • Total number of available cots • Number of available cot days • Number of occupied cot days • Number of in-utero transfers received • Number of occupied maternity bed days This dataset contained data from December 2021 to September 2023. In addition, data was collated from ScotSTAR and the Scottish Ambulance Service on in- and ex-utero transfers (October 2020 – September 2023). This data included the clinical and operational reasons that each transfer was required.
Workforce	Staffing data by professional role and grade (where relevant), including: • Budgeted and in-post Whole Time Equivalent (WTE) / Headcount • Sickness rates • Vacancy rates • Numbers of nurses who had completed their neonatal QIS This analysis covered medical roles (e.g., consultants, doctors, ANNPs), nursing and midwifery, AHPs (e.g., Dieticians, SLT, OT, and Physio), and wider supporting roles. This dataset contained data from December 2021 to September 2023.
Patient cohort	The number of babies born by the resident local authority and hospital location of birth, birthweight, and gestation. This dataset contained five years of data (April 2018 – November 2023)

2.5 Engagement

The overarching approach that has been undertaken has included engagement with both operational and strategic stakeholders at each stage of the modelling work. A summary of the stakeholders who have been engaged and the types of engagement undertaken has been included below:

Table 3 Summary of stakeholder engagement

Stakeholder groups	Engagement
Regional Chief Executives	Initial meeting with each of the three regional chief executives to discuss our approach to modelling and timelines
Strategic stakeholders (Perinatal sub-group)	Strategic stakeholders were invited to three sets of workshops: • Introduction and scope setting (including setting of initial change assumptions) • Baseline validation • Early impacts and implementation
Clinical representatives	This was a one-off session to discuss the definition of sickest babies
Operational stakeholders (North and East Scotland Health Boards)[3]	Operational stakeholders were invited to three sets of workshops: • Introduction and scope setting (including setting of initial change assumptions) • Baseline validation • Early impacts and implementation
Operational stakeholders (West Scotland Health Boards)[2]	Operational stakeholders were invited to three sets of workshops: • Introduction and scope setting (including setting of initial change assumptions) • Baseline validation • Early impacts and implementation
Regional planners	An introductory meeting was undertaken with the regional planners during project inception. Regional planners were also included in the baseline validation, early impacts, and early implementation workshops with strategic stakeholders.

The Perinatal Subgroup formed the strategic stakeholders for engagement purposes. Operational stakeholders from each of the in-scope Health Boards were invited to take part in engagement workshops. Each region was asked to nominate operational representatives from a range of professions (including neonatologists, neonatal nurses, AHPs etc.) to attend these workshops.

[3] It was discussed during project inception how to best split the two sets of operational workshops. It was agreed with Scottish Government that this would be based on the region that each Health board operates within (North, East and West).

2.6 Implementation considerations

Throughout the baseline analysis and engagement with stakeholders, feedback was received that related to the implementation of the new model of care. This has been collated and synthesised and as such, implementation considerations have been included within this report. These can be reviewed by Scottish Government, regional planners, and individual units to inform implementation plans on the future model of care.

2.7 Limitations

Due to the compressed timeframes available for data collection, individual sites had limited time to extract and validate the neonatal data. In many cases this also required a degree of manual collation and calculation to complete datasets, which are also reliant on accurate recording of information on local systems.

There have been some differences in extraction approaches across units and variability in the quality and coverage of data received. We have commented on individual baseline outputs where we believe this to have caused a material difference to result and validated this through the modelling stages via stakeholder workshops. Examples include one site not being able to provide granular data on neonatal interventions and another only being able to provide data pertaining to the sickest and/or smallest babies (rather than all neonatal admissions) in the time frame available. A full list of data limitations can be found in Annex A.

Other limitations relate to the scope of the analysis. Existing LNUs and SCUs in Scotland fell outside the scope of this report. The modelling includes an assumption that activity in these units will not change under the new model. A full analysis of maternity capacity was also not included within the remit of this commission, but the additional demand on the three future NICU sites has been estimated, recognising that neonatal units very much rely on capacity for maternity admissions.

Workforce requirements have also been excluded from this demand and capacity modelling exercise. This will form part of the regional implementation plans beyond the commission of this modelling.

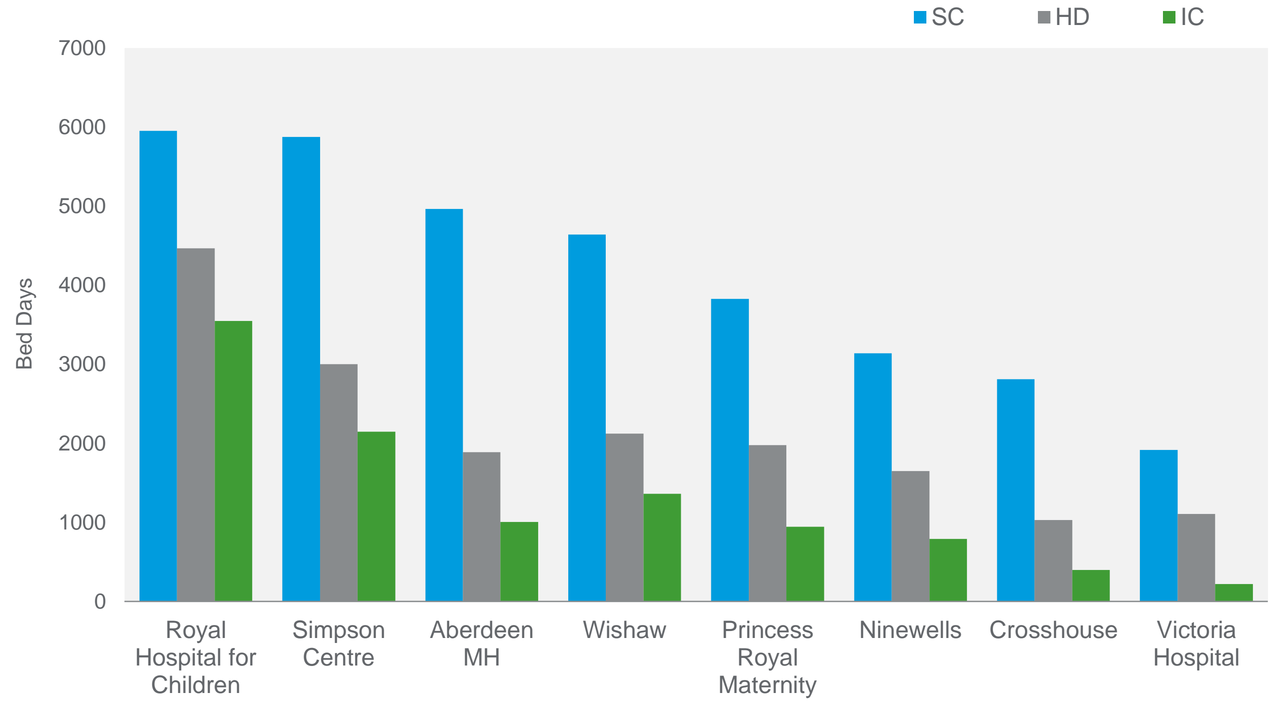
3. Baseline Summary

Analysis of collected neonatal data was undertaken and tested with strategic and operational stakeholders as a key first step in the creation of a validated baseline for modelling, feedback was collated and used to update the baseline and ensure reliable and appropriate interpretation of the data. This section of the report outlines a summary of this exercise to highlight how this analysis has shaped the model baseline and assumptions.

3.1 Activity

Across Aberdeen Maternity Hospital, Simpson Centre (Edinburgh), and Royal Hospital for Children (Glasgow), there were a total of 6,699 IC care days over the year to September 2023. This is approximately 64% of the total ICU care days across the current NICU sites. Four units saw overall care days decrease between 2022 and 2023. The largest units (Royal Hospital for Children and Simpson Centre) saw increases. Activity (admissions) has generally followed a similar pattern indicating a relatively consistent length of stay over time.

Figure 3 Bed days by level, Total October 2022 – September 2023



3.1.1 Gestation

Figure 4 below below identifies new admissions into each unit (based on a day of life recorded as less than or equal to one). There were 284 new singleton admissions across the eight sites, and 110 multiple admissions over the three-year period from October 2021 to September 2023.

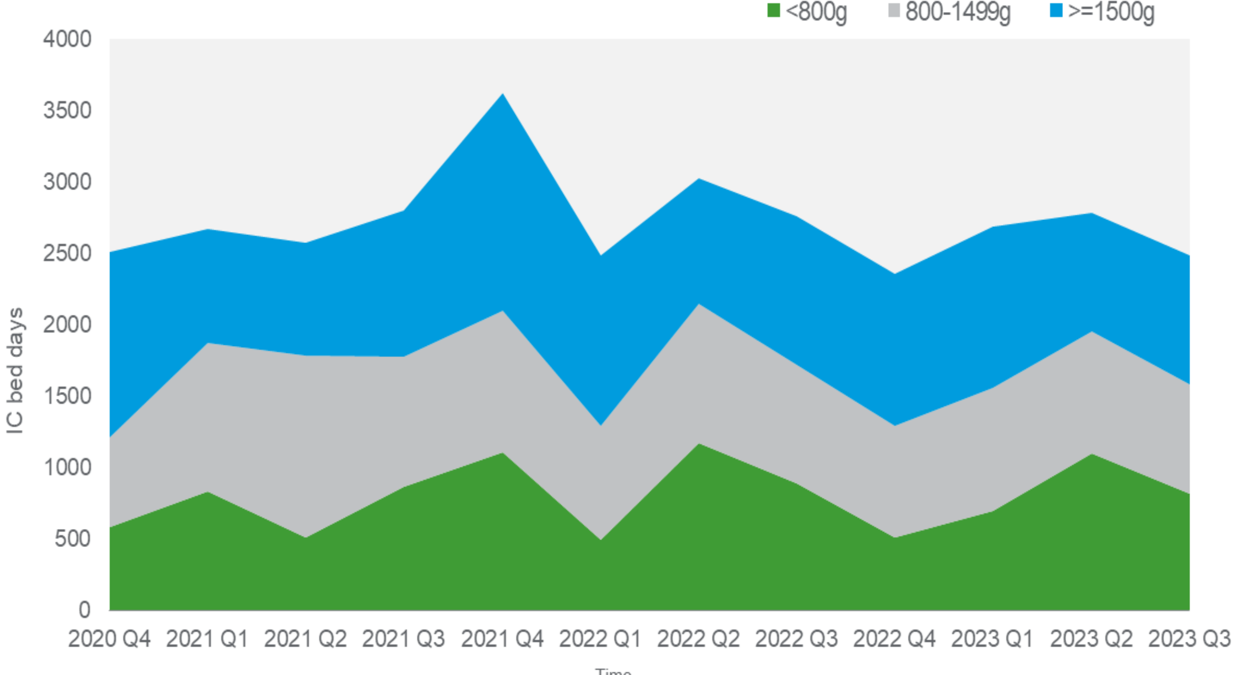
Analysis has shown a peak in activity observed in the fourth quarter (Q4) of 2021, but beyond this generally based on the data provided, there is sufficient stability to use the most recent twelve-month period as the model baseline. The exception is Wishaw who saw fewer new pre-term admissions in October 2022 to September 2023 compared to the same period in previous years, particularly compared against the peak in 2020/21. Based on discussions with Wishaw, there was no explainable reasons for this trend, and it had not continued in more recent months - based on this local intelligence it was agreed that the future modelling be based on a baseline of Sept 21 – Oct 22 (which represents a midpoint) to account for this, for the Wishaw site only.

Figure 4: Gestation split, by site and year – Total YTD Oct - Sept (2021, 2022, 2023)

3.1.2 Birth weight

Across the eight units over the last three years there were 957 new admissions in the 800g–1499g birth weight range and 310 in the sub-800g birth weight range. Despite the small volumes, low birth weight categories consume similar intensive care days compared to the >=1500g birth weight category, as evidenced by Figure 5, below.

Figure 5: Weight Split, by IC bed days Total (All Units) - 2020 Q4 to 2023 Q3

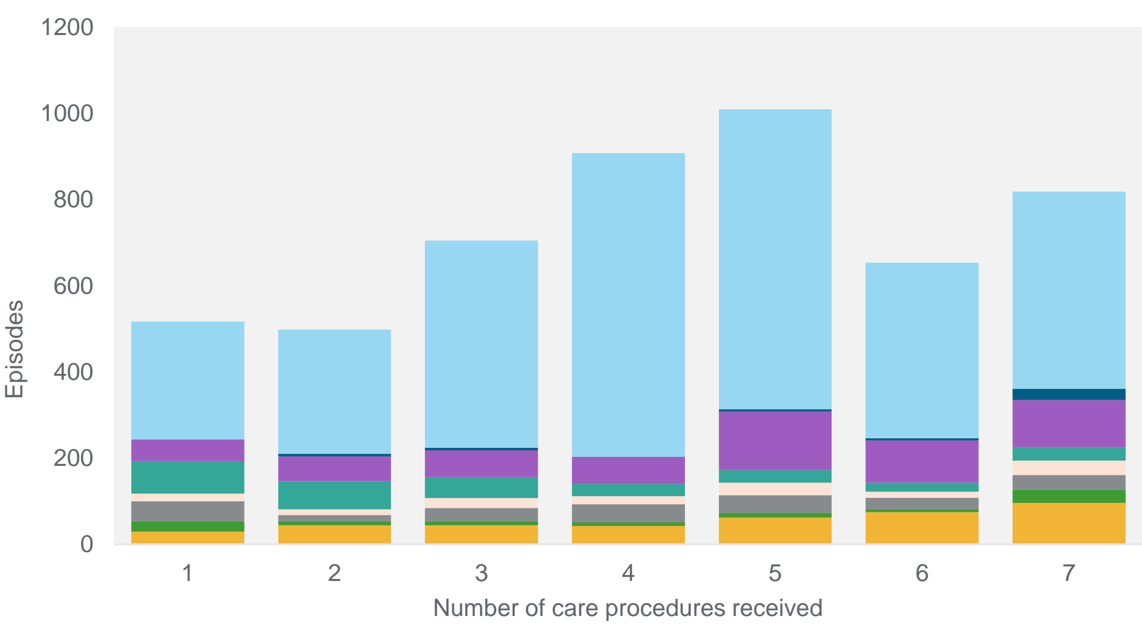


3.1.3 Sickest babies

For the purposes of our modelling of impacts we worked with clinicians to identify a data definition for those considered to be the sickest babies to help us understand the levels of care that these babies receive, informed by the Best Start Criteria.

The data capture does not allow us to fully identify each episode of care that would align with the sickest cohort however criteria have been flagged within the activity data as potential proxies (in combination) to estimate the size of this cohort. The chart below illustrates the volumes of treatments received against the number of criteria where this could be identified across the eight units. Babies within Neonatal intensive care are likely to receive a number of interventions during their stay, and we have utilised this information to help define and model the size of the sickest cohort.

Figure 6 Treatments received for IC babies based on number of criteria met



3.1.4 Overall cohort size

Based on the data definitions for the smallest and sickest babies, the baseline volumes seen are as follows. The baseline days at identified future LNU sites will proportionately move to the closest available NICU site in the future.

Table 4: Pre Term Gestation Cohort

Pre Term Gestation Cohort		
Future designation	**3 Identified NICUs**	**5 Identified LNUs**
IC Days in Cohort	2,256	997
HD Days in Cohort	2,433	1,393
SC Days in Cohort	867	420

Table 5: Low Weight Cohort (not Including pre term Gestation)

Low Weight Cohort (not Including pre term Gestation)		
Future designation	**3 Identified NICUs**	**5 Identified LNUs**
IC Days in Cohort	441	609
HD Days in Cohort	455	558
SC Days in Cohort	235	301

Table 6: Sick Baby Cohort (not including low weight / pre term)

Sick Baby Cohort (not including low weight / pre term)		
Future designation	**3 Identified NICUs**	**5 Identified LNUs**
IC Days in Cohort	2,173	829
HD Days in Cohort	2,003	877
SC Days in Cohort	1,620	1,135

Table 7: Extended IC Stay Cohort (not including above)

Extended IC Stay Cohort (not including above)		
Future designation	**3 Identified NICUs**	**5 Identified LNUs**
IC Days in Cohort	260	275
HD Days in Cohort	295	293
SC Days in Cohort	478	637

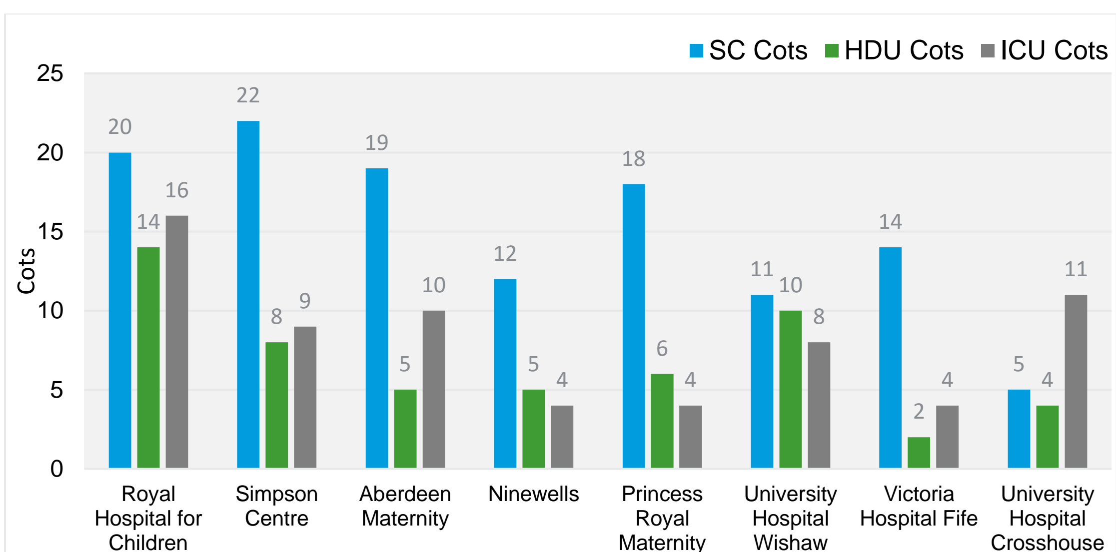
Table 8: Combined NICU Cohort

Combined NICU Cohort		
Future designation	**3 Identified NICUs**	**5 Identified LNUs**
IC Days in Cohort	5,129	2,710
HD Days in Cohort	5,186	3,120
SC Days in Cohort	3,200	2,493

3.2 Capacity

The chart below shows the current total number of cots available at each of the eight sites[4]. This represents the designated physical capacity available, independent of staff capacity, which is an important point given that we have heard that operationally, the staffing of these cots is seen as the most common reason for lack of capacity (rather than cot availability).

Figure 7 Cot availability, per site and cot type



Most units operate capacity with a degree of fluidity between each level of care, this is apparent when analysing current utilisation of this capacity, as the data illustrates a tendency to 'over-utilise' HD cots, which is a reflective of most units not having designated HD cots but providing HD level care either in the IC or SC areas of their units.

Overall unit occupancies vary from approximately 55% to 80% compared against designated available physical capacity. Although the cots are used flexibly, gaining an understanding of capacity required at each level (based on agreed future average occupancy) should be considered in modelling of future requirements, which will also inform required staffing.

[4] Note that AMH operate two configurations, 10 IC / 5 HD / 19 SC and 10 IC / 7 HD / 17 SC. The former is most often used (due to staffing).

Table 9: Unit occupancy by level of care

Unit Occupancy	ICU	HDU	SCU	Combined
Aberdeen Maternity	28%	103%	72%	63%
Royal Hospital for Children	61%	87%	86%	78%
Simpson Centre	65%	103%	73%	75%
Ninewells	54%	151%	61%	81%
Princess Royal Maternity	65%	90%	58%	75%
Victoria Hospital Fife	15%	152%	38%	54%
Wishaw	58%	54%	106%	70%
Crosshouse	22%	70%	70%	55%

3.3 Transfers

Throughout Scotland, babies are transferred both in and ex utero by ScotSTAR and the Scottish Ambulance service. The below tables provide a summary on the number of in and ex utero transfers each hospital received between October 2021 and September 2023. Note: this activity is also included in the previous activity and capacity data shared by units.

Table 10: Transfers by type, October 2021 – September 2023

	Ex utero[5]					In utero				
Units	Uplift (for additional care)	Lack of Resources / Capacity	Repatriation	Out-patients	Other	Lack of Capacity	Clinical reasons	Clinical and capacity	No reason recorded	Total
Aberdeen MH	105	1	90	10	1	1	21	19	4	**252**
Ninewells	16	5	83	0	1	2	24	34	2	**167**
Princess Royal Maternity	34	11	97	3	0	6	54	43	7	**255**
Royal Hospital for Children	818	11	26	20	9	1	63	21	6	**975**
Simpson Centre	148	0	55	0	6	8	61	47	6	**331**
Crosshouse	19	9	107	0	0	5	14	16	2	**172**
Wishaw	50	16	185	2	0	8	46	39	6	**352**
Victoria Hospital	11	12	73	0	1	3	14	24	0	**138**

[5] Note that the categories in this table are based on ScotSTAR data collection. Uplift is a transfer to another hospital for continuing or higher medical care. Resources and capacity may reference lack of equipment, cot space or staffing. Repatriation is transfer to another hospital closer to home.

4. Scenarios and assumptions to model impacts

The baseline period for the model is the twelve months from October 2022 to September 2023 (the most recent period at the outset of the project). The exception to this is the data collected from University Hospital Wishaw for which data from October 2021 to September 2022 was identified as being a more reflective baseline (see baseline section 3.1.1) for modelling.

4.1 Modelled scenarios and assumptions

Within the demand and capacity modelling, there are a series of scenarios which have been modelled. These include:

4.1.1 Demographic Projections

Population Change has been modelled based on the Population Projections for Scottish Areas (2018-based) for Age 0. The source of this is National Records Scotland. The population projections have been calculated at a Local Authority level and applied to the activity data at this level, based on the patient local authority of residence, to provide projected demographic change for each unit.

Incidence trends have been modelled to reflect expected trends in the incidence of a baby receiving neonatal care. This is to reflect the feedback that there is a trend towards providing active survival-focused care for extremely preterm infants (22-24 weeks of gestation) which brings high-intensity needs for longer periods. This has been assumed 1.5% growth per year for 22–24-week gestation. This effectively counters population change (reductions) for NICU sites.

4.1.2 Smallest Cohort

Gestation has been modelled on the basis of 100% of extremely preterm babies transferred to one of the three identified NICU sites, comprising *all* babies born at less than 27 weeks and *all* multiples at less than 28 weeks.

Birthweight: There is one principle modelled scenario for birthweight. 100% of babies with a birthweight of less than 800g will be transferred to the three identified NICU sites.

4.1.3 Sickest Cohort

We have worked with clinicians to identify a data definition for more mature babies considered the sickest informed by the Best Start Criteria and likely to require transfer. The data capture does not allow full identification of each episode of care that would align with criteria of complexity, such as "support of more than one organ in addition to respiratory support with an endotracheal tube (ETT)", however criteria have been flagged within the activity data as potential proxies (in combination) to estimate the size of this cohort.

Recognising the challenge in retrospectively identifying this cohort, we have modelled a range of scenarios including a "minimum", "likely" and "maximum" scenario to estimate impact and analyse the sensitivity of differing proportion of babies transferred to the three identified NICU sites. A summary of these three scenarios has been included below, it is worth noting that these proxy criteria are for the purposes of sizing the likely cohort only, and do not represent agreed guidelines (for example it may be seen as beneficial for all babies receiving therapeutic hypothermia to be transferred under the new model, as reflected in the 'maximum' scenario).

Table 11 Neonatal intervention categories – sizing the sickest cohort

	Likely	Minimum	Maximum
Required a surgical procedure	100%	100%	100%
Received nitric oxide	100%	100%	100%
Receiving therapeutic hypothermia and ventilated via ETT (> 6h)	100%	50%	100%
Required a chest drain greater than 48 hours (beyond day 1 of life)	100%	50%	100%
Required Exchange transfusion	100%	50%	100%
Required an inotrope and ventilation	100%	50%	100%
Received High Frequency Oscillatory Ventilation (HFOV)	100%	50%	100%
Received therapeutic hypothermia (not ventilated via ETT)	50%	25%	100%
Required an inotrope (no ventilation recorded)	50%	25%	100%
Required ventilation via tracheal tube beyond 1 day	25%	10%	50%
Required intubated ventilation support on day 3 of life	25%	10%	50%
Required intubated ventilation support on day 3 and day 4 of life	40%	20%	60%
Required intubated ventilation support on day 3 and day 5 of life	60%	30%	80%

Prolonged IC stay babies that have not been identified in previous cohorts have also been included within the sickest cohort. To estimate the "ventilated at 48 hours and not improving" group in seen in the criteria, we have made an overall assumption over the proportion babies not already meeting other criteria, who receive intensive care for over 48 hours (LoS greater than two days). Similarly, we have modelled scenarios for prolonged IC stay babies based on a likely (25% of babies will be moved), minimum (10% of babies will be moved) and maximum (50% of babies will be moved) scenario.

Table 12 Neonatal intervention categories – intensive care LoS

	Likely	Minimum	Maximum
Extended LoS in intensive care (over 2 days)	25%	10%	50%

4.1.4 Shift of days by level of care

Of the identified smallest and sickest cohort, the future modelling has assumed that the majority of IC days consolidate at the three NICU sites, as well as a proportion of the HD days prior to repatriation, and only a very small proportion of SC days:

- **95%** of IC days of the identified cohort will shift to the nearest identified NICU
- **33%** of HD days of the identified cohort will shift to the nearest identified NICU
- **5%** of SC days of the identified cohort will shift to the nearest identified NICU

The 95% figure is based on feedback from sites that there will be some occasions where transfer is not possible or desirable, and marginal preterm cases where a baby is not deemed to require a transfer. Similarly, the 5% is a recognition that although almost all babies will have been repatriated to their local LNU prior to

requiring this level of care, feedback has suggested that there will be a small proportion where this is not possible due to logistical or other reasons. 33% of HDU days is based on an average of 48 hrs in HDU against an overall average stay in HDU of 6 days. For modelling purposes for longer stays such as those seen for the extreme preterm and more complex cases, it is assumed that this overall proportion will hold.

4.1.5 Geographical flows

The core assumption is that future flows will follow the ethos of the Best Start Programme, to deliver care in the nearest appropriate centre, and modelling will assume that patterns of referrals follow the principle that activity from the five future LNU sites will be delivered in the nearest appropriate NICU centre in the future (based on postcode district where available, or the proportion of the local authority closest to each site). We have assumed that current flows to the three NICU sites would remain consistent.

To understand the sensitivity of this assumption, we have modelled a second scenario of historical flows, to understand the impact if neonatal activity follows historical ICU referral patterns.

4.1.6 Current and future occupancy

Future occupancy rates for neonatal cot requirements have been modelled based on an average of 80% across SC and HD cot days and 65% for IC cot days. This is to account for the additional variation in IC demand over time, as seen in the baseline analysis.

This will give a required operational (staffed) capacity in future requirements and has also been contrasted with the current available (physical) cot capacity for which the following rates are based.

Table 13: Current Occupancy Rates

Site	Current IC Occupancy	Current HD Occupancy	Current SC Occupancy
Aberdeen Maternity	28%	103%	72%
Royal Hospital for Children	61%	87%	86%
Simpson Centre	65%	103%	73%
Ninewells	54%	151%	61%
Princess Royal Maternity	65%	90%	58%
Victoria Hospital Fife	15%	152%	38%
University Hospital Wishaw	58%	54%	106%
University Hospital Crosshouse	22%	70%	70%

4.1.7 Maternity capacity for in-utero transfers

We have sought to estimate the anticipated additional impact of in-utero transfers on maternity services in the three NICU sites. This has been based on the following assumptions:

- There are approximately 6 in-utero admissions for every 10 new neonatal admissions to IC or HD cots (including those who do deliver and those who do not)
- The average number of maternity bed days is 5.2 per in-utero transfer maternity admission.

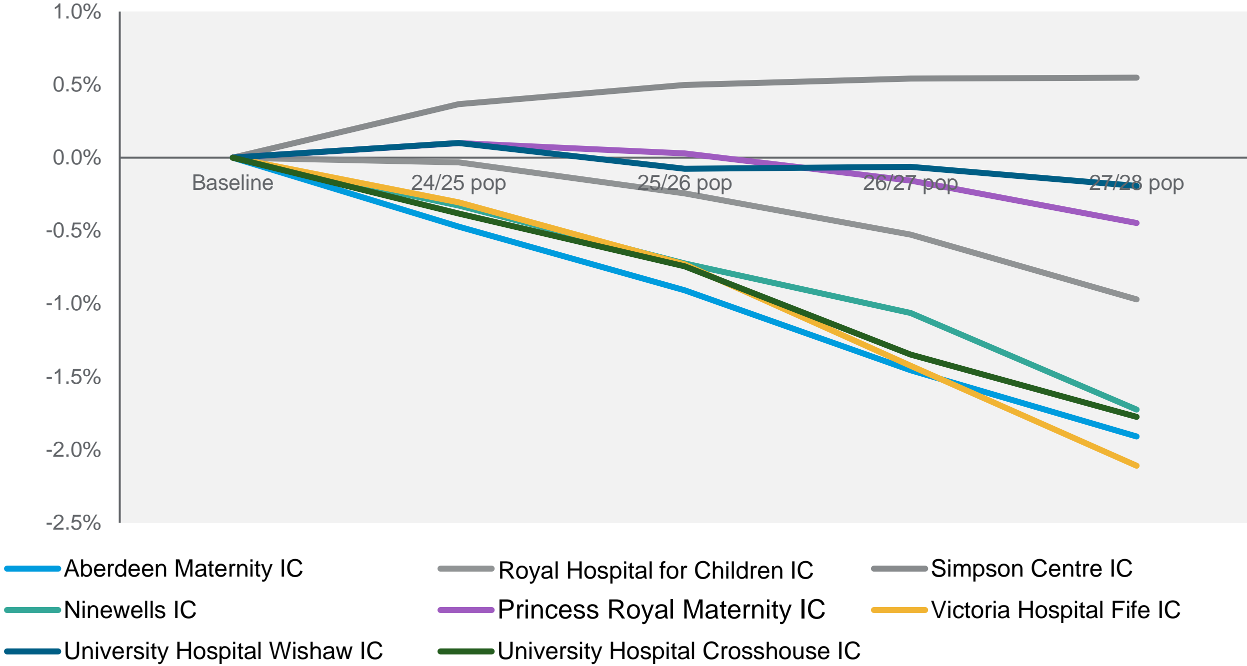
These assumptions have been based on limited information and should be tested further as part of more focussed review of local maternity unit capacity, including the ability for maternity services at each of the NICU sites to manage additional demand.

5. Modelled impacts

5.1 Demographic projections

Population projections vary by local authorities for the age 0 age group with the highest in Midlothian (plus 5% over 5 years) and the lowest in the Shetland Islands (minus 7% over 5 years), and a Scotland average of minus 1% over 5 years. The impact of applying demographic projections is a therefore a slight reduction in expected demand over time for most units, with the exception being the Simpson Centre given the expected growth in the catchment population for Neonatal services.

Figure 8: Projected Impact of demographic change on IC activity



5.2 Scenario outputs

The following waterfall charts illustrate the impact of each modelled scenario for each unit. Each chart includes the following steps:

- **Declared Capacity** - (*Full Base capacity*) this is the total available physical capacity in the baseline period (irrespective of whether this capacity has been utilised or fully staffed).
- **Required Capacity** - (*Adjusted Occupancy*) this is the nominal capacity to accommodate baseline delivered activity after adjustment for target occupancy rates. This is also a measure of the level of staffed capacity required to meet baseline demand levels.
- **2026/27 Population projections and modelled Incidence trends** - This represents demand in the patient cohort changes as a result of population change and the modelled increase in extreme preterm cases, and the resulting change in capacity requirements.
- **Shift Gestation Cohort / Shift Weight Cohort** - This represents the change in required capacity to accommodate the change in the flow of babies <27 weeks or <800g.
- **Shift Interventions Cohort / Shift IC Extended Days Cohort** - This represents the change in the flow of babies who receive IC interventions and those who fail to improve at LNUs.

- **Total -** This is the final predicted capacity required to meet activity, given the modelled flow of babies into and out of each unit.

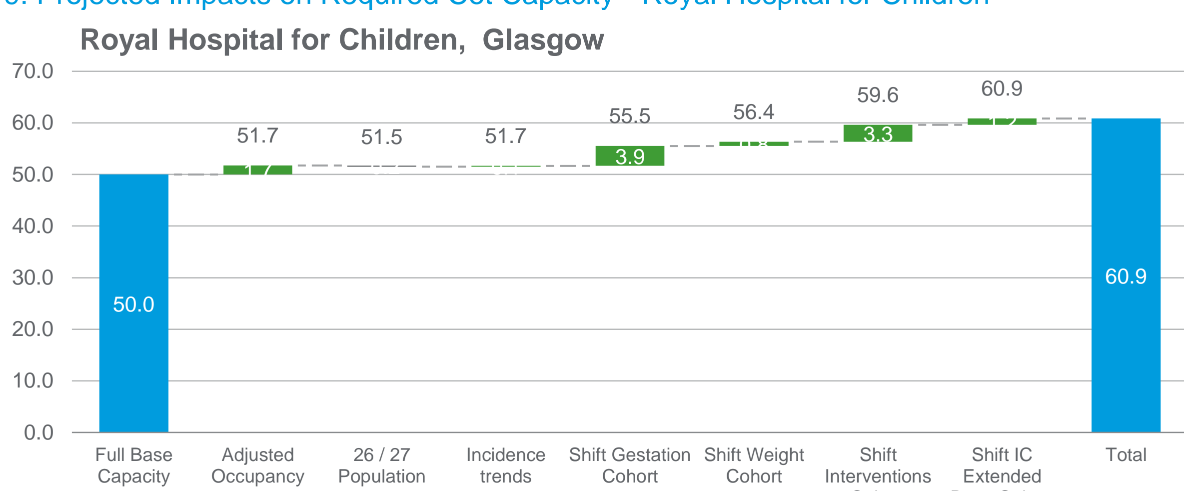
Under each chart, the table details the impact on SC, HD, and IC cots, as well as the difference that ‘low’ and ‘high’ scenarios have on projected requirements where this is different to the ‘likely’ scenario.

5.2.1 Royal Hospital for Children, Glasgow

The projected activity for Royal Hospital for Children (RHCG) required an overall increase of around 12 cots, consisting of 6.5 IC cots, 3.6 HD and 1.8 SC cots. The biggest expected rise is for the transfer in of babies <27 weeks or <800g, requiring an additional 5.7 cots (4.2 IC).

While an additional 12 cots have been identified for RHCG, there may be capacity to have the care of neonates requiring high dependency or special care located in either of the two LNUs within the Glasgow and Greater Clyde Health Board – either at Princess Royal Maternity (see 5.2.5) or at Royal Alexandra Hospital Paisley. This would support the capacity at RHCG to handle the increase, especially with lower acuity cases (mainly in SC cot capacity), where babies do meet the criteria of ‘smallest and sickest’ during their stay.

Figure 9: Projected Impacts on Required Cot Capacity - Royal Hospital for Children

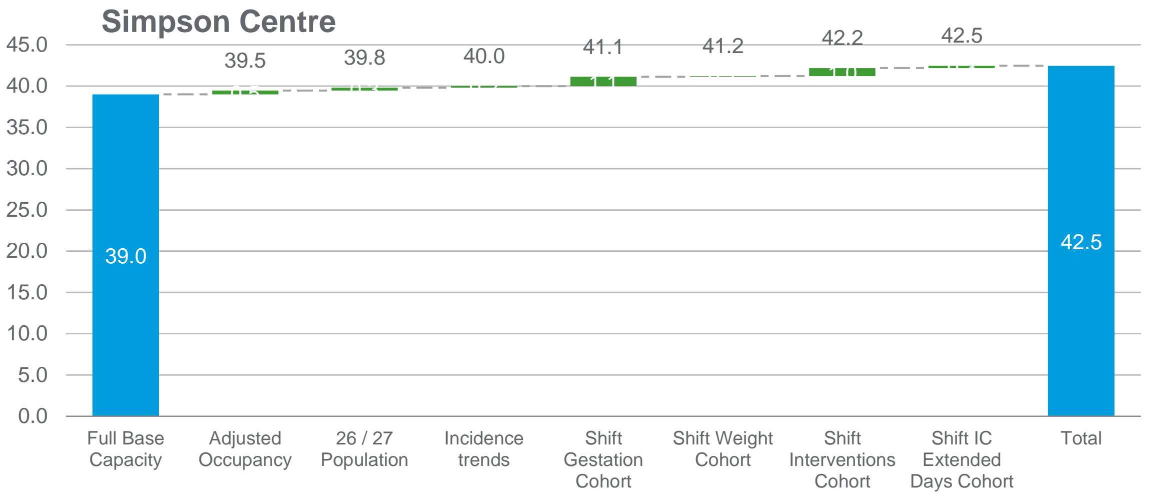


Royal Hospital for Children	SC	HD	IC
Current Physical Capacity	20.0	14.0	16.0
Baseline Capacity Requirement	21.5	15.3	15.0
Projected Capacity Requirement	21.8 (21.7 to 21.9)	17.6 (17.2 to 17.9)	22.5 (21.1 to 23.5)

5.2.2 Simpson Centre

The projected increase in activity for The Simpson Centre would need approximately 4 further cots, with increases mainly in IC and HD capacity; overall modelling indicates a change in configuration with slightly lower SC capacity compared to baseline (-1.6), versus more substantial HD (+3.2) and IC (+2.4) increases. The biggest change in the number of required cots is driven by the movement of babies <27 weeks or <800g in the new model of care.

Figure 10: Projected Impacts on Required Cot Capacity – Simpson Centre

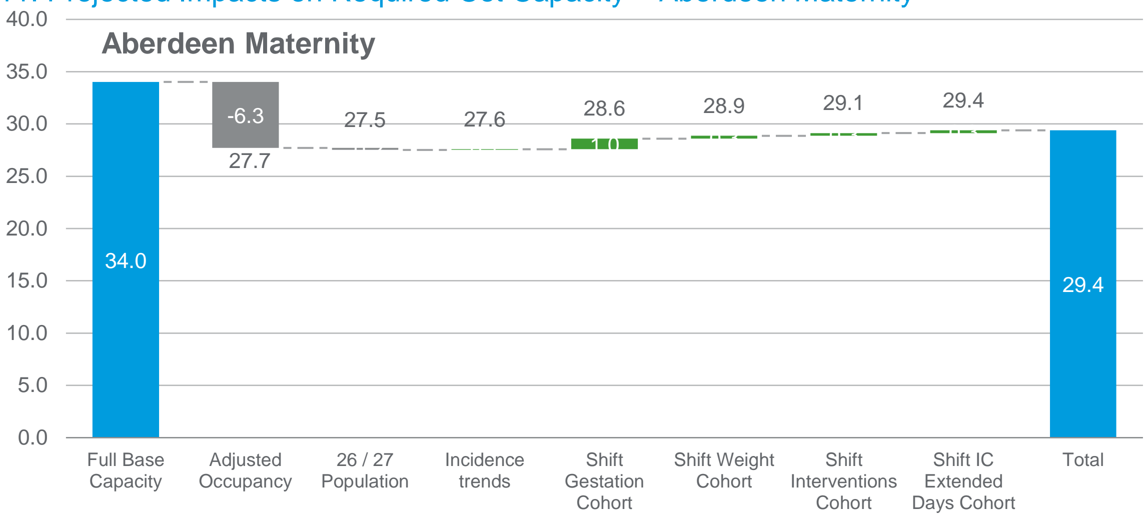


Simpson Centre	SC	HD	IC
Current Physical Capacity	22.0	8.0	9.0
Baseline Capacity Requirement	20.1	10.3	9.0
Projected Capacity Requirement	20.4	11.2 (11.1 to 11.3)	11.4 (11.2 to 11.7)

5.2.3 Aberdeen Maternity

Aberdeen Maternity Hospital currently has more physical neonatal care capacity than is currently utilised by the activity supported, particularly in IC capacity. Based on activity, this suggests that the unit utilised 28 cots in the baseline period . This cot capacity would increase to 30 cots given the model of care changes.

Figure 11: Projected Impacts on Required Cot Capacity – Aberdeen Maternity



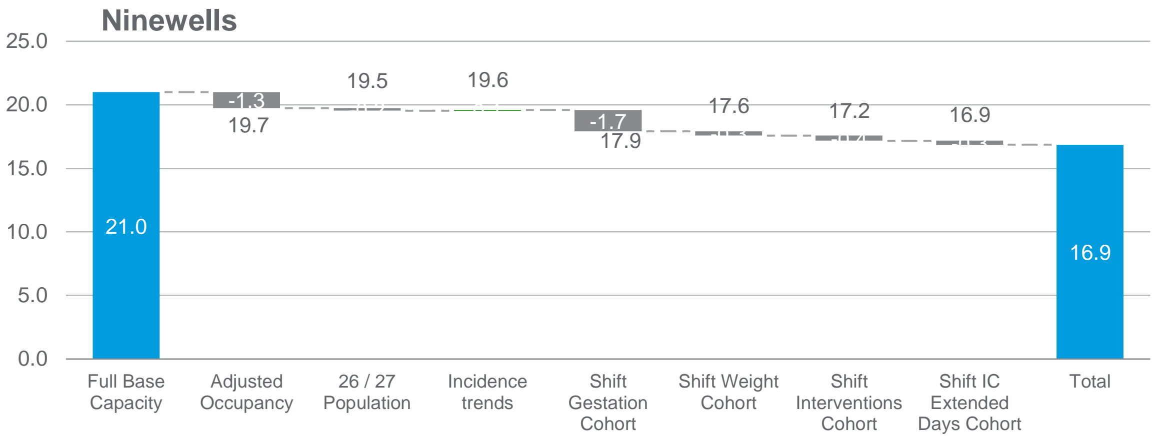
Aberdeen Maternity	SC	HD	IC
Current Physical Capacity	19.0	5.0	10.0
Baseline Capacity Requirement	17.0	6.5	4.2
Projected Capacity Requirement	17.0	6.9 (6.9 to 7)	5.5 (5.3 to 5.8)

5.2.4 Ninewells

Projected requirements for Ninewells show an overall reduction in physical capacity requirements of 4 cots, particularly with IC cot requirements reducing from 4 to 1.4. This decrease in cots is driven by adjusting physical capacity based on activity (a reduction in cots of 1.3) and the movement of the smallest babies in the new model of care.

The slight increase in HD cot requirements versus physical capacity indicates the flexible use of SC and IC cots for HD babies in the baseline period.

Figure 12: Projected Impacts on Required Cot Capacity - Ninewells



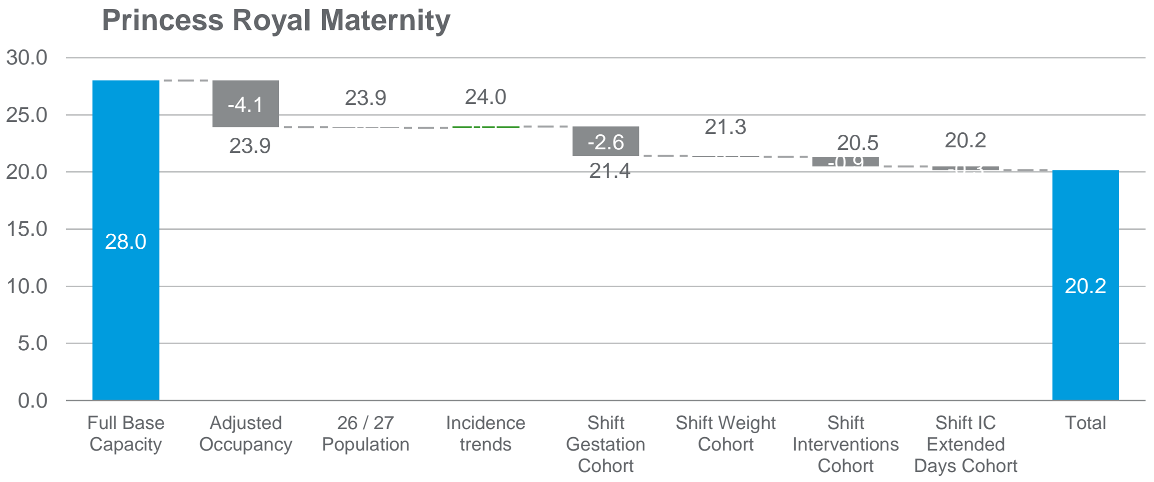
Ninewells	SC	HD	IC
Current Physical Capacity	14.0	3.0	4.0
Baseline Capacity Requirement	10.8	5.7	3.3
Projected Capacity Requirement	10.6	4.8 (4.7 to 4.9)	1.4 (1.0 to 1.7)

5.2.5 Princess Royal Maternity

The impacts on Princess Royal Maternity Hospital show a decrease in HD and IC requirements of 3 cots. At 80% occupancy the requirement for SC cots is 5 less than the available physical capacity.

While there is a total decrease in the number of cots of 7.8 for Princess Royal Maternity, these cots may be needed to support lower level of care babies, who in the baseline period would have received care in RHCG, especially with lower acuity cases (mainly in SC cot capacity), where babies do not meet the criteria of 'smallest and sickest' during their stay. This would support the capacity at RHCG to handle the increase in NICU activity.

Figure 13: Projected Impacts on Required Cot Capacity – Princess Royal Maternity

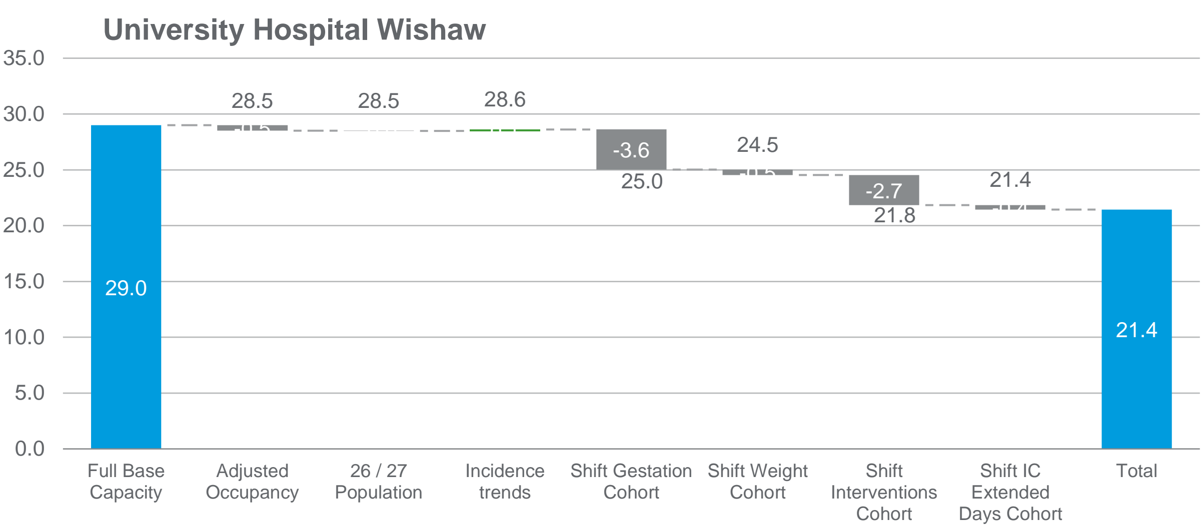


Princess Royal Maternity	SC	HD	IC
Current Physical Capacity	18.0	6.0	4.0
Baseline Capacity Requirement	13.2	6.8	4.0
Projected Capacity Requirement	13.0 (12.9 to 13.0)	5.7 (5.5 to 5.8)	1.4 (1.1 to 1.7)

5.2.6 University Hospital Wishaw

The projection for Wishaw is an overall decrease in approximately 7 cots, predominantly in IC capacity (a reduction of 6.4 cots). There is also a configuration change with a higher proportion of SC cots to meet baseline and future demand – of an additional 3.4 cots. This increase in special care cots will support the timely repatriation of babies in the new model of care.

Figure 14: Projected Impacts on Required Cot Capacity – University Hospital Wishaw



University Hospital Wishaw	SC	HD	IC
Current Physical Capacity	11.0	10.0	8.0
Baseline Capacity Requirement	14.6	6.7	7.2
Projected Capacity Requirement	14.4 (14.3 to 14.4)	5.5 (5.4 to 5.8)	1.6 (1.1 to 2.5)

5.2.7 Victoria Hospital Fife

As an early adopter site, Victoria Hospital has a large difference between physical capacity and utilised capacity, for the same reason the site does not see a significant additional impact in the projected capacity requirements, this is because the majority of activity in the smallest and sickest cohorts will have already moved under the early implementer arrangements. The future modelled requirement for IC cots is only 0.5, and consideration will need to be given to the practical configuration (ie is there a safe minimum number of cots that needs to be upheld) and the associated staffing required.

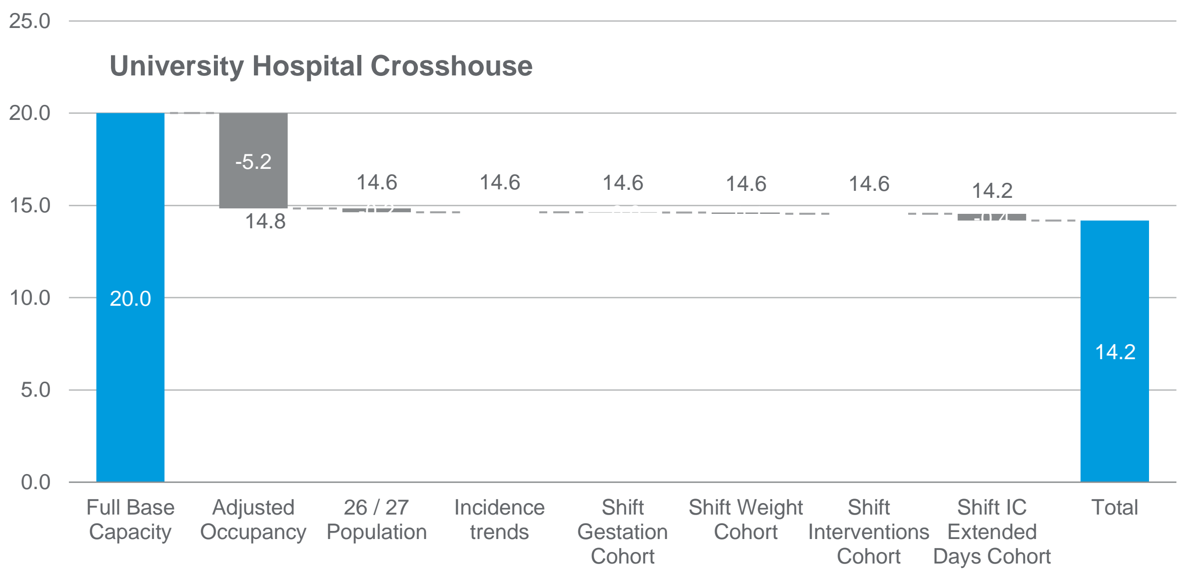
Figure 15: Projected Impacts on Required Cot Capacity – Victoria Hospital Fife

Victoria Hospital Fife	SC	HD	IC
Current Physical Capacity	14.0	2.0	4.0
Baseline Capacity Requirement	6.6	3.8	0.9
Projected Capacity Requirement	6.5	3.5 (3.4 to 3.5)	0.5 (0.3 to 0.6)

5.2.8 University Hospital Crosshouse

University Hospital Crosshouse follows a similar pattern to Victoria Hospital, which is reflective of being an early adopter of the model of care. There is a notable difference (-5.2 cots) in physical capacity compared to required capacity in the baseline, mainly due to IC cot requirements (-3.3 cots), but only very minor changes due to any further shift in activity. It is worth noting that the projected change as part of the 'sickest' cohort does not show any impact, due to a lack of granular baseline data for the Crosshouse site, meaning it was not possible to identify the more complex interventions in the same way as other sites.

Figure 16: Projected Impacts on Required Cot Capacity – University Hospital Crosshouse



University Hospital Crosshouse	SC	HD	IC
Current Physical Capacity	11.0	4.0	5.0
Baseline Capacity Requirement	9.6	3.5	1.7
Projected Capacity Requirement	9.5	3.4	1.3 (1 to 1.5)

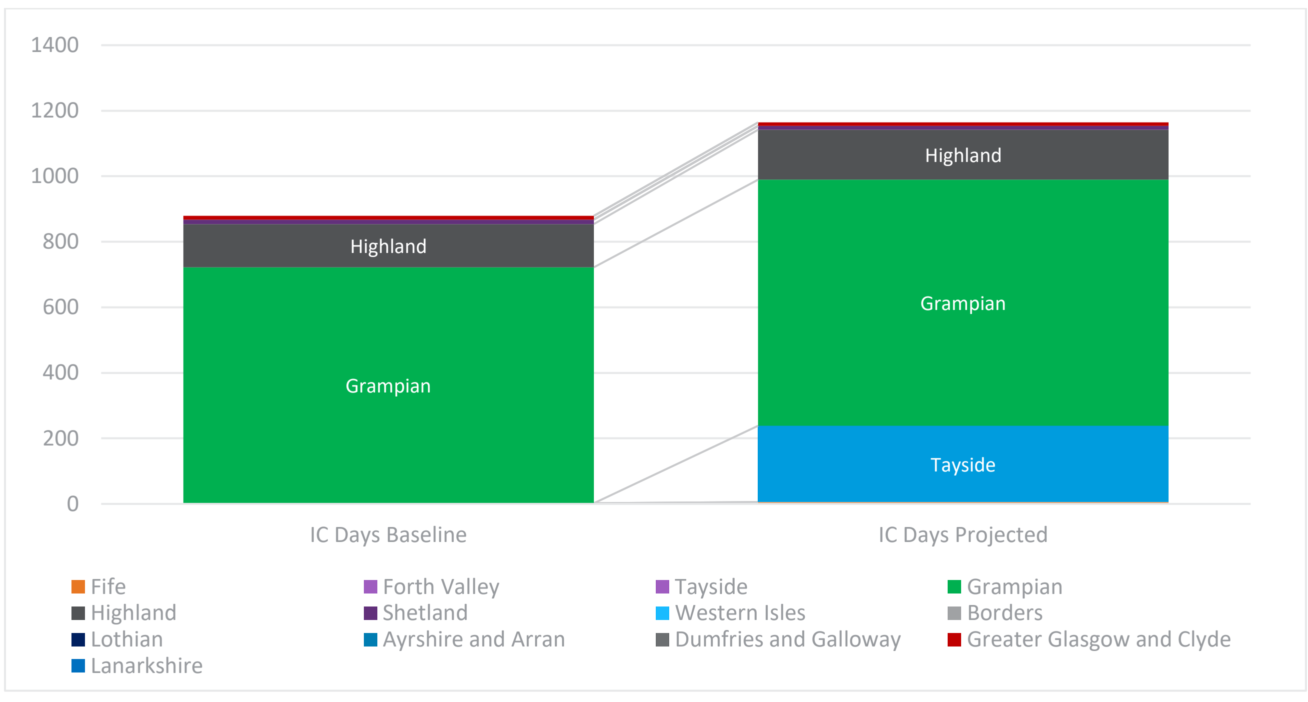
5.2.9 Impact on flows

The following charts illustrate the modelled changes in flow by Health Board, which indicate the key changes in catchment areas for each NICU and the projected distribution of activity.

Aberdeen Maternity Hospital

The most significant change for Aberdeen Maternity Hospital is the projected increase in activity from Tayside. This is due to the transfer of activity that is currently being delivered from Ninewells and will be split between the Simpson Centre and Aberdeen. Aberdeen will also expect to see small uplifts from Grampian and Highland for the same reason.

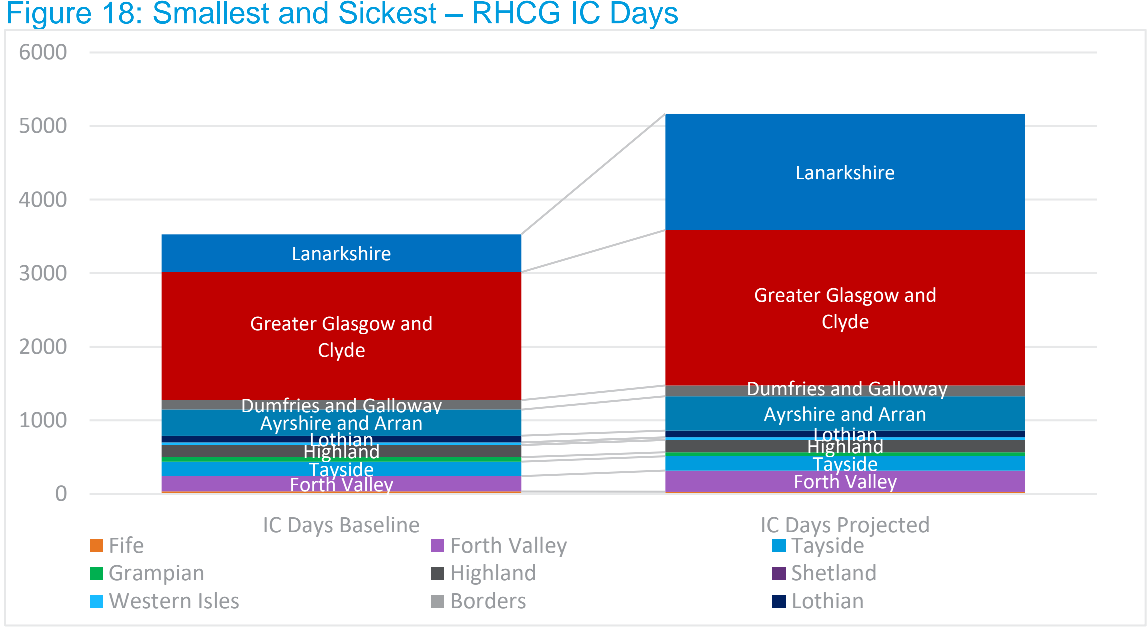
Figure 17: Smallest and Sickest - Aberdeen Maternity Hospital IC Days



Royal Hospital for Children, Glasgow

RHCG is projected to see a significant increase in the activity seen from Lanarkshire, as that activity would have previously been undertaken at Wishaw. There is also a large increase from Greater Glasgow and Clyde – mainly due to the shift from Princess Royal Maternity, but also some activity that would have previously been undertaken at Wishaw. Smaller increases are projected from Ayrshire and Arran, which would have previously been undertaken by a combination of Crosshouse, Wishaw or Princess Royal Maternity. Forth Valley activity, currently delivered across a range of units, will also increase. However, comparatively more activity from Forth Valley Health Board is projected to flow to The Simpson Centre as the nearest NICU site.

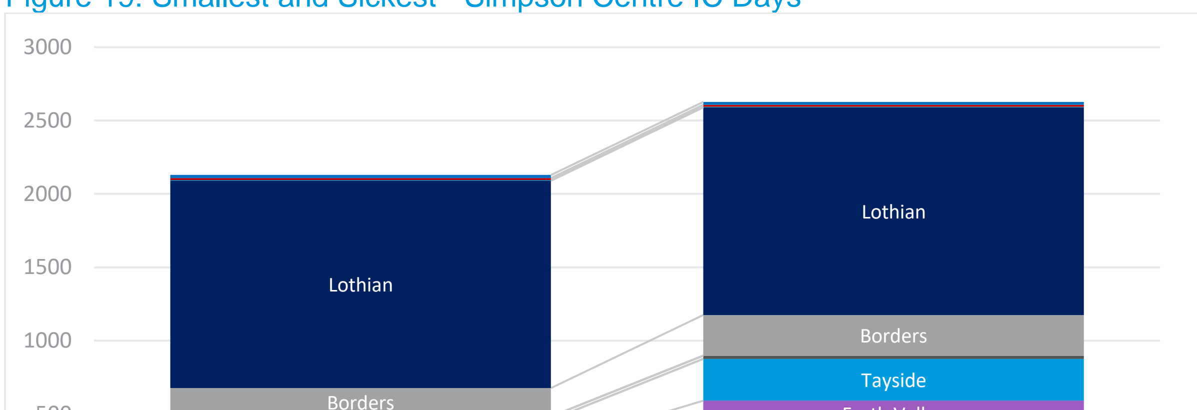
Figure 18: Smallest and Sickest – RHCG IC Days



Simpson Centre

The Simpson Centre is projected to receive more intensive care activity particularly from Fife (previously delivered by Victoria Hospital) and Forth Valley (currently mainly delivered by Wishaw), with a share from Tayside, and the majority of the Borders activity that currently flows to Wishaw.

Figure 19: Smallest and Sickest - Simpson Centre IC Days

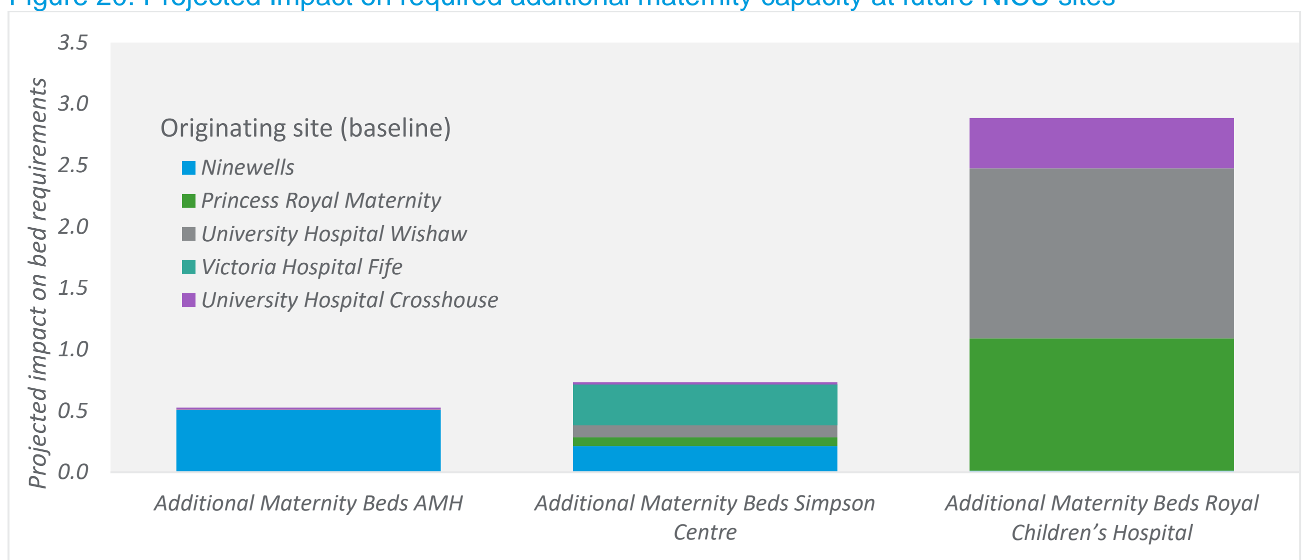


5.2.10 Maternity capacity

Based on the modelling of future neonatal flows and the assumptions regarding associated uplift in demand on maternity services, the projected increase in maternity activity comprises 163 additional bed days for AMH, 227 for Simpson Centre and 895 for RHCG.

The equivalent bed capacity that would need to be resourced is included in Figure 20, assuming an average occupancy of 85% to allow for variation in demand over time. For births for preterm less than 27 weeks and 800g babies that are not in the correct setting, mothers would require postnatal transfer alongside their infant and inpatient care if needed. Considerations would also be needed as maternal care in this group has been described as complex.

Figure 20: Projected Impact on required additional maternity capacity at future NICU sites



5.2.11 Impact on transfers

The change in the model of care will impact on both the volume of transfers and journey travel times.

It is difficult (with the data available in the timeframe of this work) to determine the activity that is already transferred in utero in the baseline period, and we would recommend further work to collect and test and validate transfer impact assumptions. We have based a planning assumption on the overall ratio of 6 in-utero transfers to 10 new neonatal admissions (see 0 maternity assumptions) to IC or HD cots. We have assumed that modelled changes in the location for in utero transfers would not result in additional journeys, under the logic that the transfer would be to a different location, but not an additional journey for SAS. This would nonetheless result in an increased travel time.

We have assumed that based on this overall proportion, a volume of activity moving under the new model would potentially require an ex-utero transfer. This results in an estimate of an additional 100 Ex utero transfers per year for the ScotSTAR service, though ideally a higher proportion of babies within the identified cohorts will be transferred antenatally to ensure births occur in the correct setting. In practice, the experience in England is that that approximately 90% of births for preterm less than 27 weeks and 800g babies occurs in the correct setting, meaning that this number will be an overestimate.

Table 14: Potential transfer volumes by unit and destination

Booking Hospital	Ex Utero Transfer to Aberdeen Maternity	Ex Utero Transfer to RHCG	Ex Utero Transfer to Simpson Centre
Ninewells	6	0	3
Princess Royal Maternity	0	28	1
University Hospital Wishaw	0	48	4
Victoria Hospital Fife	0	0	7
University Hospital Crosshouse	0	3	0

In addition to these uplift transfers, we estimate approximately 79 additional repatriation transfers per year, for ex-utero transfers returning from the NICU sites to these LNU sites. Additionally, there would be approximately 50 additional repatriations for babies initially transferred in-utero.

Based on travel time analysis (Google Maps Distance Matrix API, see Figure 22), this would require an additional 64 hours of transportation per year, with an average travel time of 38 minutes. The average journey times vary from an average of 19 minutes (for activity displaced from PRM), to an average of 1 hour and 26 minutes (for activity displaced from Ninewells).

Given that the major impacts are projected for transfers moving from either Wishaw and Princess Royal Maternity to Royal Hospital for Children, it should be emphasised that this is an overestimate, but at the same time is an impact to be planned for and mitigated in order to minimise excess transfers. We would recommend further work to understand this as part of regional implementation planning.

Figure 21 below illustrates the main drivers of potential impact, with the new model altering the pathway for just over 50 babies per year in the 'smallest' cohort, and the potential for close to 100 for the 'sickest' cohort.

Figure 21: Potential for additional transfers – projected impact on location for in utero and ex utero transfers

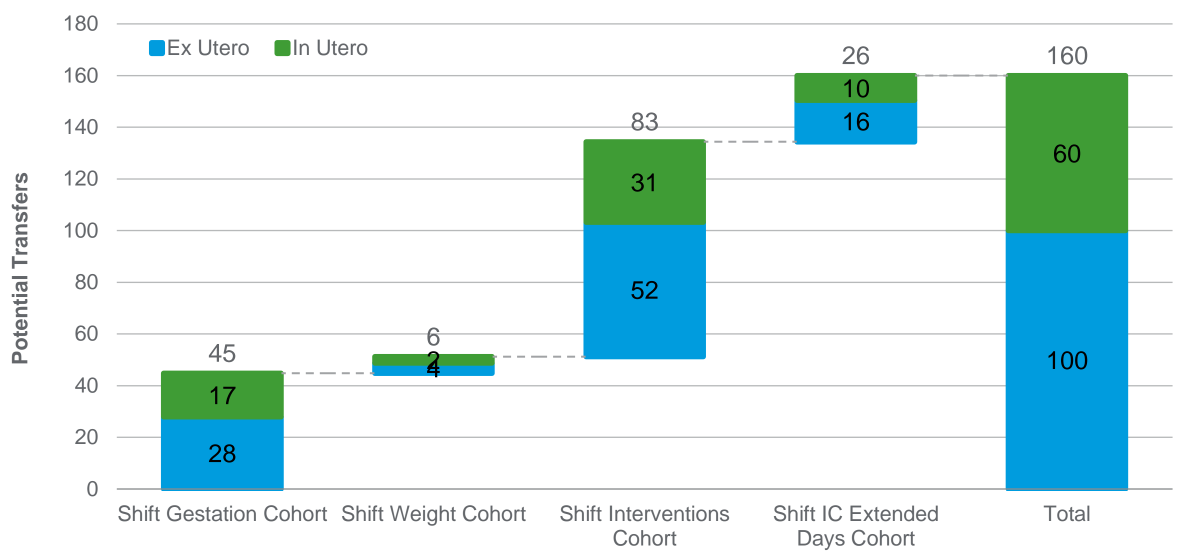
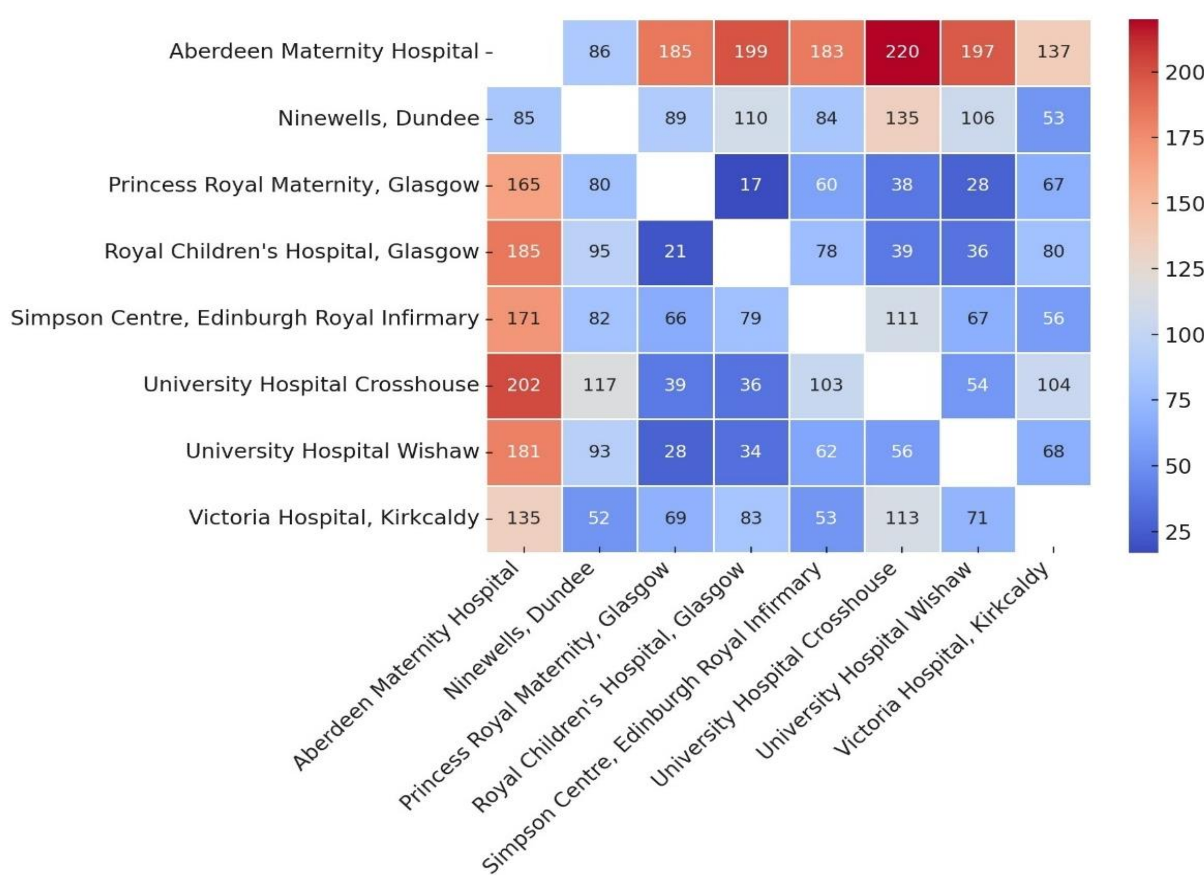


Figure 22: Travel times between hospitals (in minutes)



6. Implementation

6.1 Lessons learnt from other areas

To inform considerations for implementation, learning has been gleaned from similar models of care that have been implemented in other areas. Experience from England suggests that 85-90% of births should happen in the correct setting and any increase in maternity transfers can be mitigated by using a firm guideline to ensure that risk stratification is optimised to underpin this. Furthermore, women giving birth at extremely low gestations have themselves increased health needs due to the conditions necessitating early delivery[6]. Implementation must therefore be monitored carefully to ensure that guidance is followed, and that care occurs in the appropriate setting. The development of firm monitoring criteria is necessary with regular review and exception reporting in situations where the patient pathway is not followed. These should be monitored by teams in each of the NICU-associated networks and reported centrally.

The flow of babies is not simply one way and, given current high survival rates and likely pressure on beds from the stochastic nature of neonatal admissions, it is also imperative within this model to ensure that staff are in place to optimise back transfer without delays, capacity is present in receiving units and that transfer policy and delays to this are minimised and monitored. Again, the experience of transformation in England has highlighted the important of Family Care Coordinators in supporting families though this difficult transition and minimising differences in family care practices at the constituent Network units.

Care and attention will be needed to support communication and liaison where exceptions to practice may occur. Intensive care activity (and expertise) will still be required in non-NICU sites and consideration given to Network wide skills and training to support this. Outreach by NICU teams to optimise these areas will be important. Regular publication of national outcomes (through NHS Scotland and the National Neonatal Audit Project to benchmark performance within the Scottish Network) is essential.

6.2 Implementation considerations

As a part of the engagement with operational and strategic stakeholders throughout the modelling process, a range of feedback has been provided, that will need to be considered during the implementation of the future national model of care. This has been captured and summarised into four key themes: Workforce; Capacity and occupancy; NICU flows and repatriation; and Implementation enablers. Each of these themes and implementation considerations has been shared and refined during the final set of workshops with stakeholders. The final set of implementation considerations have been summarised in tables below and will be for consideration of Scottish Government and the Regional Planning teams to take forward.

The primary area which will need to be considered prior to implementation is workforce, with this thematic area significantly interlinking with capacity and NICU flows.

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[6] Morgan, A.S., Waheed, S., Gajree, S. et al. Maternal and infant morbidity following birth before 27 weeks of gestation: a single centre study. Sci Rep 11, 288 (2021). https://doi.org/10.1038/s41598-020-79445-1

6.2.1 Workforce

What we have heard	What does this mean for implementation
Workforce has been identified as fundamental to the successful implementation of the future national model of care, with the recruitment of neonatal nurses / midwives recognised as an ongoing challenge	In order to ensure the there is sufficient staff to meet the capacity requirements projected within the capacity modelling, there will need to be consideration of a workforce model for each region. This should align with the BAPM guidance on safe staffing. Workforce planning will also need to consider the recruitment of any additional workforce, alongside supporting the retention of current staff in-post.
There is a nominal threshold of medical staffing that is required to be met (including ANNPs). Reducing the number of cot days at the future LNUs may not correlate to a reduction in medical workforce required in these units.	BAPM guidance relating to the medical workforce should be reviewed when considering regional workforce planning to meet the demand.
Where there have been transfers out of a baby's normal pathway of care within the baseline period for a lack of capacity in the nearest suitable centre, a lack of neonatal nurses is seen as one of the main reasons. As well as overall capacity, there is also a high sickness absence in this workforce.	Levels of sickness absence will need to be considered within initial workforce planning (in terms of WTE staff required). In the medium-term, a review of sickness absence (to determine whether any additional supports can be provided) should be undertaken.
The role of wider supporting care roles (outside of medical and nursing/midwifery) should be explored as part of the future model, to ensure optimal outcomes for babies. There should also be consideration of the required non-clinical roles and the footprint of these roles (e.g. educators and clinical co-ordinators etc).	As a part of the regional workforce planning, consideration will need to be made for wider clinical roles (e.g AHPs, Pharmacists, Psychological support services etc.) and non-clinical roles based on BAPM guidance.
There will also need to be consideration for the educational requirements (e.g Neonatal QIS for nursing / midwifery workforce) and over what time horizon this will need to be achieved, to ensure skills maintenance across units.	During implementation planning, there will need to be consideration of any changes in the numbers of nurses / midwives required to staff the future model of care and how this will impact education requirements. For example: taking into account BAPM guidance for the proportion Neonatal QIS staff required (70%), a forward plan to support units to meet these requirements is recommended.

6.2.2 Capacity

What we have heard	What does this mean for implementation
Maternity capacity has been raised as a frequent and increasingly more common barrier to IUT in situations where there is neonatal capacity but a lack of capacity to accept women in labour. Maternity length of stay can be lengthy (pre delivery as well as following delivery) as many of these women will be high risk and require significant complex care. Units very much rely on capacity for maternity admissions.	While the modelling has outlined the additional bed days necessary to support increased in-utero transfers in the maternity services, the capacity and policy of local maternity units on-site at each of the three designated NICU sites should be reviewed. This review will need to address how maternal care is delivered within maternity services alongside each NICU site and to understand where pressure points for each site may occur
Staff capacity is seen as the most common reason for lack of capacity (rather than cots), and operationally the staffing of these cots is the limiting factor rather than the number of physical cots.	In order for the future model of care to be implemented, staff capacity will need to be sufficient for the capacity requirements projected within the modelling (see workforce theme above for more details).
Due to the model scope, there still needs to be consideration of the work which has historically been transferred to LNUs (which was outside of the scope for this modelling)	Individual units should review where capacity transferred have been required to units who were outside the scope of this modelling. This information should be considered alongside these modelling outputs.

6.2.3 NICU flows and repatriation

What we have heard	What does this mean for implementation
Across each of the eight units, there have been both in- and ex-utero transfers as a result of capacity. Patient flows outside these normal pathways (although reduced) may still occur in the future model due to the stochastic nature of NICU admissions. This will need to be appropriately managed.	During implementation planning, good practice co-ordination approaches should be considered. Examples of this include: • Use of co-located maternity hospital with neonatal services • Adoption of family-centred care principles Consideration co-ordinators to support flows (e.g family care co-ordinator overseeing repatriation)
Sufficient staffed capacity will be required at LNU sites to allow for timely repatriation.	During workforce planning (see workforce theme above), considerations will also need to be given to the staffing of wider LNU units (to prevent unnecessary transfers to NICU sites, and to enable the flow for timely repatriation so that these sites have the capacity to take babies back). Safe staffing guidance from BAPM and the principles from the National Neonatal Discharge Planning and Follow-up Framework (2019) should be considered.
There are a number of areas suggesting a lack of community and transitional care infrastructure, which has an impact on the length of stay for babies in those areas. Improving community and transitional care will improve flows and free up capacity in LNU and thus NICUs.	Within regional implementation planning, forward planning around how community and transitional care can be improved to reduce cot days and send babies home (where appropriate).

6.2.4 Implementation enablers

What we have heard	What does this mean for implementation
Data for the current modelling exercise had to be manually collated. As a result, data collection is not standardised across units. There is an ongoing challenge around the collation of data at a regional / national level for the purposes of service planning.	The establishment of a standardised monitoring dashboard (incorporating in key activity, capacity and flows etc.) across all units would ensure consistency in the national model of care and support in the evidence-based identification of pressure points.
Wider support services (e.g temporary accommodation for parents) have been mentioned throughout engagement with stakeholders.	During implementation planning, a review of the current wider supporting services would identify any key supporting enablers across each region, alongside areas which may need further support (to further enhance the national model).
A range of stakeholders have queried how the future model of care will be financed, citing a range of operational challenges which could be influenced by the future funding model.	It is critical that an agreement on the financial arrangements for the future model of care is made, prior to its implementation. This should form part of the initial next steps following this modelling exercise. The focus of the financial model will need to promote safe, high-quality care for Scottish babies.
There is an acknowledgement that there will be a significant level of change for operational staff as the future model of change is embedded.	Comprehensive communication plans should be developed as part of the implementation considerations, to ensure transparency and that all staff are informed throughout implementation.

Annex A – Data Limitations

Within the available time for this work there have been some differences in extraction approaches across units, variability in the quality and coverage of data received. Key limitations and mitigation approaches are included in the table below.

Table A1: Data limitations and mitigations

Source	Limitation	Mitigation
Aberdeen Maternity – activity data	Due to manual extraction needed, data has only been available in the timeframe for the smallest and sickest cohort, rather than full neonatal activity. This cohort has also been identified by searching electronic badger records for relevant search term, which may underestimate the cohort.	All infants who were identified by search criteria were manually reviewed by the AMH team for accuracy, and more aggregated totals have been used to provide the totality of neonatal activity for AMH.
Simpson Centre – activity data Ninewells – activity data	Data provided for these sites has not included a 'day of life at admission' field, making identification of distinct new admissions (rather than total episodes of care) difficult.	An overall episode to new admission ratio has been applied to estimate the number of new admissions for the given episodes.
University Hospital Crosshouse	Due to limited resources available in the neonatal team, and limited BI team access to the badger system, admissions data from local SMR02 data has been used. This is not at a granular level, meaning that it has not been possible to identify the sickest cohort using detailed flags, and estimates have been necessary to apportion total cot days to levels of care.	Estimates have been calculated based on known totals. As an early implementer, the impact on the Crosshouse site beyond baseline is not expected to be as significant as other sites, however the inability to identify the full cohort should be a recognised limitation.
Ninewells – activity data	Criteria with a flag for those requiring a chest drain was shown to be inaccurate and has been excluded.	Minimal impact is expected given the low activity volumes with this flag seen for other sites.

Annex B – Travel Times

Travel Times between Hospitals

Travel Times Between Hospital Sites – Without Traffic								
Units	**Aberdeen Maternity Hospital**	**Ninewells, Dundee**	**Princess Royal Maternity, Glasgow**	**Royal Hospital for Children, Glasgow**	**Simpson Centre, Edinburgh Royal Infirmary**	**University Hospital Crosshouse**	**University Hospital Wishaw**	**Victoria Hospital, Kirkcaldy**
Aberdeen Maternity Hospital		1 hr, 24 mins	2 hrs, 39 mins	2 hrs, 49 mins	2 hrs, 39 mins	3 hrs, 8 mins	2 hrs, 53 mins	2 hrs, 4 mins
Ninewells, Dundee	1 hr, 25 mins		1 hr, 20 mins	1 hr, 31 mins	1 hr, 19 mins	1 hr, 50 mins	1 hr, 33 mins	53 mins
Princess Royal Maternity, Glasgow	2 hrs, 39 mins	1 hr, 20 mins		15 mins	58 mins	35 mins	26 mins	1 hr, 5 mins
Royal Hospital for Children, Glasgow	2 hrs, 51 mins	1 hr, 31 mins	16 mins		1 hr, 10 mins	36 mins	33 mins	1 hr, 17 mins
Simpson Centre, Edinburgh Royal Infirmary	2 hrs, 39 mins	1 hr, 20 mins	58 mins	1 hr, 8 mins		1 hr, 27 mins	1 hr	53 mins
University Hospital Crosshouse	3 hrs, 8 mins	1 hr, 49 mins	33 mins	35 mins	1 hr, 27 mins		51 mins	1 hr, 34 mins
University Hospital Wishaw	2 hrs, 52 mins	1 hr, 33 mins	26 mins	32 mins	1 hr	52 mins		1 hr, 7 mins
Victoria Hospital, Kirkcaldy	2 hrs, 5 mins	52 mins	1 hr, 4 mins	1 hr, 14 mins	52 mins	1 hr, 34 mins	1 hr, 6 mins	

Travel Times Between Hospital Sites – With Traffic Added								
Units	**Aberdeen Maternity Hospital**	**Ninewells, Dundee**	**Princess Royal Maternity, Glasgow**	**Royal Hospital for Children, Glasgow**	**Simpson Centre, Edinburgh Royal Infirmary**	**University Hospital Crosshouse**	**University Hospital Wishaw**	**Victoria Hospital, Kirkcaldy**
Aberdeen Maternity Hospital		1 hr, 26 mins	3 hrs, 6 mins	3 hrs, 19 mins	3 hrs, 3 mins	3 hrs, 41 mins	3 hrs, 18 mins	2 hrs, 18 mins
Ninewells, Dundee	1 hr, 25 mins		1 hr, 29 mins	1 hr, 50 mins	1 hr, 24 mins	2 hrs, 15 mins	1 hr, 47 mins	54 mins
Princess Royal Maternity, Glasgow	2 hrs, 45 mins	1 hr, 20 mins		17 mins	1 hr	38 mins	28 mins,	1 hr, 7 mins
Royal Hospital for Children, Glasgow	3 hrs, 5 mins	1 hr, 36 mins	21 mins		1 hr, 18 mins	39 mins	37 mins	1 hr, 21 mins
Simpson Centre, Edinburgh Royal Infirmary	2 hrs, 52 mins	1 hr, 22 mins	1 hr, 6 mins	1 hr, 19 mins		1 hr, 51 mins	1 hr, 8 mins	57 mins
University Hospital Crosshouse	3 hrs, 23 mins	1 hr, 57 mins	39 mins	37 mins	1 hr, 43 mins		54 mins, and 3	1 hr, 44 mins, and 48 secs
University Hospital Wishaw	3 hrs, 2 mins	1 hr, 34 mins	29 mins	35 mins	1 hr, 3 mins	57 mins		1 hr, 9 mins
Victoria Hospital, Kirkcaldy	2 hrs, 15 mins	53 mins	1 hr, 10 mins	1 hr, 23 mins	54 mins	1 hr, 53 mins	1 hr, 11 mins	

Source: Google Maps Distance Matrix API via the googleway package in R Studio

Annex C – Projected impacts

Projected Impacts on Required Cot Capacity

Intensive Care Cots

Scenario	Aberdeen Maternity IC Cots	RHCG IC Cots	Simpson Centre IC Cots	Ninewells IC Cots	Princess Royal Maternity IC Cots	Victoria Hospital Fife IC Cots	University Hospital Wishaw IC Cots	University Hospital Crosshouse IC Cots
Baseline	10.0	16.0	9.0	4.0	4.0	4.0	8.0	5.0
Adjusted Occupancy	(5.8)	(1.0)	0.0	(0.7)	(0.0)	(3.1)	(0.8)	(3.3)
26 / 27 Population	(0.1)	(0.1)	0.0	(0.0)	(0.0)	(0.0)	0.0	(0.0)
Incidence trends	0.0	0.1	0.1	0.0	0.1	-	0.1	-
Shift Gestation Cohort	0.7	3.7	1.5	(1.1)	(1.8)	-	(2.9)	-
Shift Weight Cohort	0.2	0.5	0.0	(0.2)	(0.0)	-	(0.4)	(0.0)
Shift Interventions Cohort	0.2	2.6	0.5	(0.3)	(0.6)	(0.4)	(2.1)	-
Shift IC Extended Days Cohort	0.2	0.8	0.2	(0.2)	(0.2)	(0.1)	(0.3)	(0.3)
Projection	5.5	22.5	11.4	1.4	1.4	0.5	1.6	1.3

Note: Increases and (reductions) seen in each scenario

High Dependency Cots

Scenario	Aberdeen Maternity HD Cots	RHCG HD Cots	Simpson Centre HD Cots	Ninewells HD Cots	Princess Royal Maternity HD Cots	Victoria Hospital Fife HD Cots	University Hospital Wishaw HD Cots	University Hospital Crosshouse HD Cots
Baseline	5.0	14.0	8.0	3.0	6.0	2.0	10.0	4.0
Adjusted Occupancy	1.4	1.3	2.3	2.7	0.8	1.8	(3.3)	(0.5)
26 / 27 Population	(0.1)	(0.1)	0.1	(0.1)	(0.0)	(0.1)	(0.0)	(0.0)
Incidence trends	0.0	0.0	0.1	0.0	0.0	0.0	0.0	-
Shift Gestation Cohort	0.3	1.2	0.4	(0.6)	(0.7)	(0.1)	(0.6)	(0.0)
Shift Weight Cohort	0.1	0.1	0.0	(0.1)	(0.0)	-	(0.1)	(0.0)
Shift Interventions Cohort	0.0	0.8	0.2	(0.1)	(0.3)	(0.2)	(0.5)	-
Shift IC Extended Days Cohort	0.1	0.2	0.1	(0.1)	(0.1)	(0.0)	(0.1)	(0.0)
Projection	6.9	17.7	11.2	4.8	5.7	3.5	5.5	3.4

Note: Increases and (reductions) seen in each scenario

Special Care Days

Scenario	Aberdeen Maternity SC Cots	RHCG SC Cots	Simpson Centre SC Cots	Ninewells SC Cots	Princess Royal Maternity SC Cots	Victoria Hospital Fife SC Cots	University Hospital Wishaw SC Cots	University Hospital Crosshouse SC Cots
Baseline	19.0	20.0	22.0	14.0	18.0	14.0	11.0	11.0
Adjusted Occupancy	(2.0)	1.5	(1.9)	(3.2)	(4.8)	(7.4)	3.6	(1.4)
26 / 27 Population	(0.1)	(0.1)	0.2	(0.1)	(0.0)	(0.1)	(0.0)	(0.1)
Incidence trends	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-
Shift Gestation Cohort	0.0	0.1	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Shift Weight Cohort	0.0	0.0	0.0	(0.0)	(0.0)	-	(0.0)	(0.0)
Shift Interventions Cohort	0.0	0.2	0.0	(0.0)	(0.1)	(0.0)	(0.1)	-
Shift IC Extended Days Cohort	0.0	0.1	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Projection	17.0	21.8	20.4	10.6	13.0	6.5	14.4	9.5

Note: Increases and (reductions) seen in each scenario

Projected Impacts on Care Days

Intensive Care Days

Scenario	Aberdeen Maternity IC Days	RHCG IC Days	Simpson Centre IC Days	Ninewells IC Days	Princess Royal Maternity IC Days	Victoria Hospital Fife IC Days	University Hospital Wishaw IC Days	University Hospital Crosshouse IC Days
Baseline	1,004	3,549	2,146	791	947	222	1,704	400
Adjusted Occupancy	-	-	-	-	-	-	-	-
26 / 27 Population	(15)	(19)	12	(8)	(1)	(3)	0	(5)
Incidence trends	8	17	27	7	13	-	18	-
Shift Gestation Cohort	165	880	345	(265)	(428)	-	(696)	-
Shift Weight Cohort	46	114	10	(57)	(9)	-	(100)	(6)
Shift Interventions Cohort	55	613	116	(79)	(130)	(86)	(489)	-
Shift IC Extended Days Cohort	38	179	42	(46)	(52)	(19)	(69)	(73)
Projection	1,302	5,333	2,698	342	340	114	369	316

Note: Increases and (reductions) seen in each scenario

High Dependency Days

Scenario	Aberdeen Maternity HD Days	RHCG HD Days	Simpson Centre HD Days	Ninewells HD Days	Princess Royal Maternity HD Days	Victoria Hospital Fife HD Days	University Hospital Wishaw HD Days	University Hospital Crosshouse HD Days
Baseline	1,887	4,470	3,002	1,650	1,979	1,109	1,971	1,030
Adjusted Occupancy	-	-	-	-	-	-	-	-
26 / 27 Population	(19)	(22)	25	(17)	(4)	(16)	(1)	(14)
Incidence trends	7	14	20	10	11	2	9	-
Shift Gestation Cohort	90	357	131	(163)	(208)	(28)	(178)	(3)
Shift Weight Cohort	23	42	7	(29)	(13)	-	(18)	(11)
Shift Interventions Cohort	10	225	54	(18)	(74)	(46)	(151)	-
Shift IC Extended Days Cohort	24	55	17	(28)	(22)	(12)	(24)	(12)
Projection	2,022	5,140	3,257	1,405	1,670	1,009	1,609	990

Note: Increases and (reductions) seen in each scenario

Special Care Days

Scenario	Aberdeen Maternity SC Days	RHCG SC Days	Simpson Centre SC Days	Ninewells SC Days	Princess Royal Maternity SC Days	Victoria Hospital Fife SC Days	University Hospital Wishaw SC Days	University Hospital Crosshouse SC Days
Baseline	4,968	6,271	5,879	3,140	3,842	1,932	4,255	2,811
Adjusted Occupancy	-	-	-	-	-	-	-	-
26 / 27 Population	(20)	(22)	59	(32)	(11)	(29)	(5)	(40)
Incidence trends	2	9	1	1	2	1	7	-
Shift Gestation Cohort	1	25	3	(2)	(11)	(2)	(14)	(1)
Shift Weight Cohort	0	5	1	(1)	(2)	-	(2)	(1)
Shift Interventions Cohort	1	50	6	(2)	(15)	(5)	(35)	-
Shift IC Extended Days Cohort	4	24	4	(6)	(10)	(2)	(8)	(6)
Projection	4,958	6,363	5,953	3,098	3,797	1,895	4,197	2,762

Note: Increases and (reductions) seen in each scenario

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The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Orthopaedic Hip Fracture Audit**
Responsible Executive:	**Dr Chris Mckenna, Medical Director**
Report Author:	**Mr Andy Ballantyne, Clinical Director Orthopaedics, Sarah Mitchell, Clinical Lead Orthopaedics, Fiona Cameron, NTC Manager**

Executive Summary:

- NHS Fife has been identified as a significant outlier (-3SD from national average) for the 5th consecutive year in the Scottish Hip Fracture Audit (SHFA) KPI for time to theatre for acute hip fractures.
- Whilst this KPI relates to hip fractures, this condition is recognised as a surrogate measure of the management of all orthopaedic emergency trauma.
- NHS Fife meets all other KPIs within the Scottish hip fracture audit and is a positive outlier (+3SD) for Cognitive Geriatric Assessment within 3 days.
- The recently completed trauma review process identified the need for additional trauma operating capacity as part of a wider improvement plan.
- A theatre utilisation group, established to identify or reprovision capacity has been unable to increase orthopaedic emergency trauma capacity without having a significant impact on other surgical services and waiting times.
- Projections demonstrate a future increase in demand for hip fracture surgery of around 30% due to an aging and comorbid population by 2029.
- There is a risk that without additional capacity patients in NHS Fife will suffer harm due to lack of access to timely surgery.

1 Purpose

This report is presented for:

- Discussion

This report relates to:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is presented to provide moderate assurance to the Committee of the ASD response to the 2023 Scottish Hip Fracture SNAP Audit, demonstrating NHS Fife to be an outlier for hip fracture time to theatre (<36 hours).
Public Health Scotland plan a visit to NHS Fife on 4/11/24 to discuss improvement.

2.2 Background

SHFA is part of the SNAP governance process within NHS Scotland. For hip fractures it reports against 12 standards and feeds back to outlier boards, via Public Health Scotland.

Figure 1. Scottish Standards of Care for hip fracture patients

The SHFA steering group use the following six key performance indicators (KPIs) as the basis of the annual governance process:

1. Surgical repair of the hip fracture is performed within 36 hours of admission
2. Hemi-arthroplasty implants are cemented.
3. Comprehensive geriatric assessment (CGA) has commenced within 3 days of admission
4. Percentage of patients not readmitted within 14 days
5. Percentage of patients who returned to place of origin within 30 days of admission
6. Survival within 30 days of admission

Table 1. NHS Fife attainment of KPI 6 Time to theatre over past 5 years compared to Scottish average.

KPI Time to theatre	NHS Fife attainment	Scottish average
2019	65.9%	76%
2020	66%	71%
2021	61.4%	72.12%
2022	51%	69.9%
2023	60.17%	68.68%

Table 2. 2023

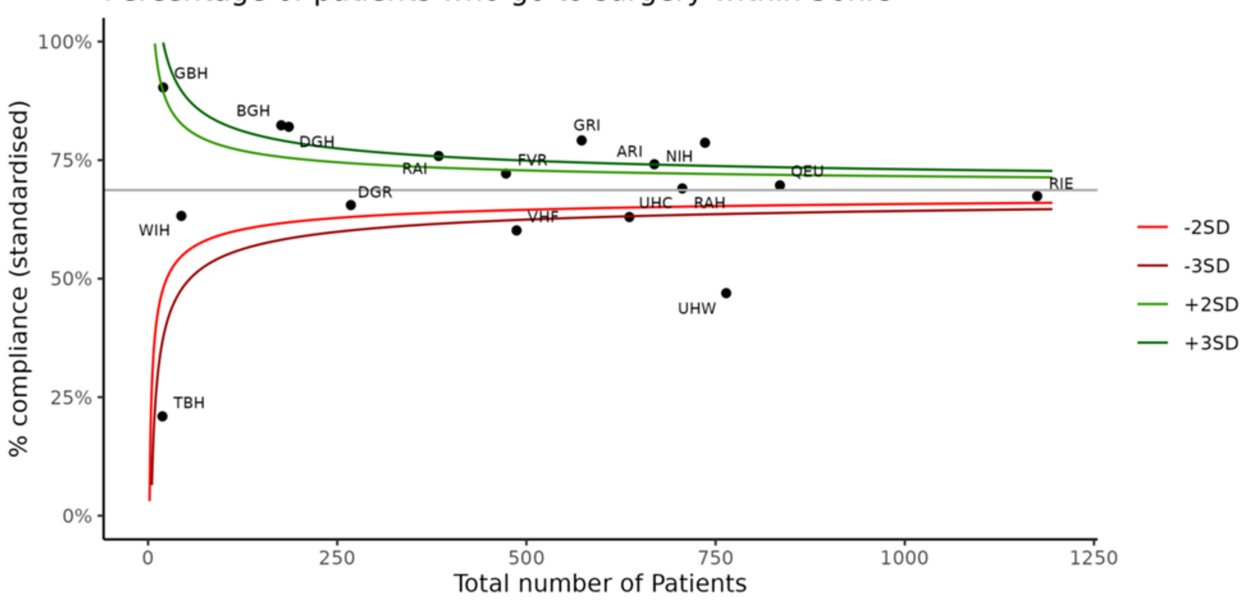
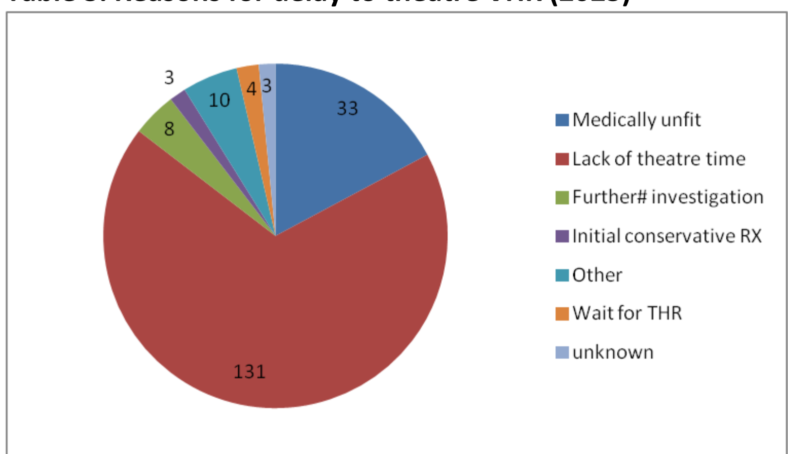


Table 3. Reasons for delay to theatre VHK (2023)



PHS have highlighted that for the fifth consecutive year that NHS Fife have failed (-3SD from national mean) to achieve the SHFA standard for time to theatre within 36 hours for hip fractures. Hip fracture is recognised as a surrogate marker for wider frailty trauma suggesting wider challenges in ensuring timely emergency trauma theatre access for all fractures.

Emergency trauma theatre capacity has also been identified as an issue within the Trauma & Orthopaedic (T&O) Peer Review 2024.

Recent publications have highlighted the projected increase in hip fracture numbers (as a surrogate indicator of all frailty fractures) of 32% by 2029. Without action, this will further exacerbate current challenges for trauma theatre provision.

2.3 Assessment

Within the Surgical Directorate there has been extensive work to transfer minor and elective surgery to the QMH site to create capacity in VHK for major surgery including trauma. Work is also ongoing to ensure efficient theatre scheduling to maximise capacity.

Prior to the audit results, Acute SLT commissioned a review of Trauma Orthopaedic services which has completed the 'discovery phase'. A list of recommendations and an improvement plan is being managed within the directorate and reports through the surgical clinical governance process to ASD CGC.

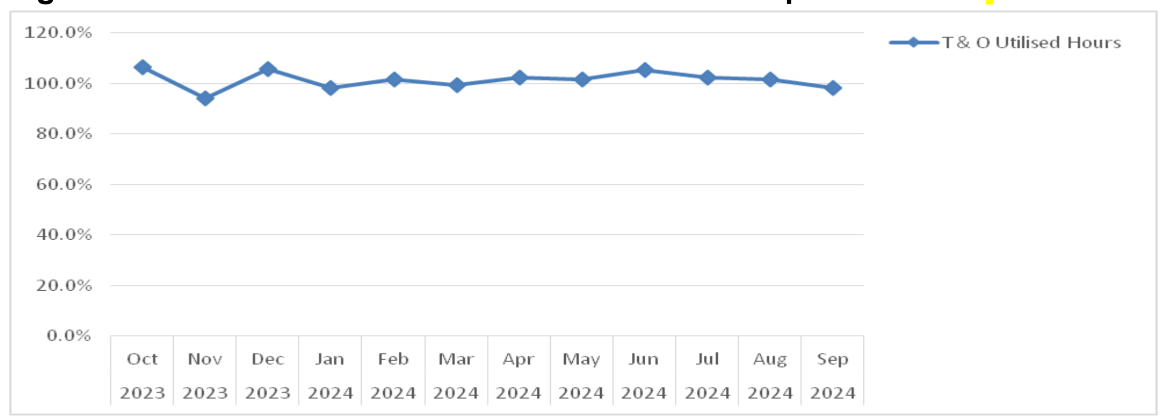
Key recommendations:

- theatre efficiencies and emergency trauma theatre capacity
- the role of trauma coordinators
- job planning

One of the key recommendations from the initial summary report was to ensure adequate funding for existing theatres, implementation of additional emergency theatre operating day, and finally a further full day operating to meet increasing demand of frailty fractures.

The orthopaedics service has visited NHS Ayrshire and Arran (A&A) and Lanarkshire as part of the T&O peer review process. A&A were a repeated outlier for time to theatre, and in previous years SHFA report they describe how they resolved this by increasing emergency trauma theatre sessions.

Figure 1: Trauma theatre utilisation October 2023-September 2024i



Locally we have reviewed trauma theatre utilisation which has run at virtually 100% for at least the last 2 years.

Consultant job planning within the Orthopaedic service shows a 77% completion as compared to 31% across Acute Services, showing a high degree of engagement.

A fortnightly theatre utilisation group has been established with the objective of identifying additional trauma theatre capacity. The intention was that this would be delivered by the 1st September 2024 as detailed within the Outlier Status return to PHS (August 2024). This group has been unable to provide additional capacity without a detrimental effect on waiting times in other surgical specialities.
Whilst physical theatre capacity exists and there is capacity within the Orthopaedic Consultant workforce, there is no theatre team available to provide these additional sessions.

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

Evidence suggests that when all the acute hip fracture standards of care are met patient outcomes improve. Delayed fixation correlates with increased one year mortality, increased complications and increased length of hospital stay. Delay past 48 hours increased one year mortality by 32% (Harris E, Clement N, MacLullich A, Farrow L. The impact of an ageing population on future increases in hip fracture burden. Bone Joint J. 2024;106-B(1):62-68).

2.3.2 Workforce

Implementing additional theatre sessions from 2019 to date has resulted in unfunded cost pressure within the theatre staff group.

Consultant job planning is near completion and there is recognition that flexibility will be required to support additional trauma theatre. There is capacity to fulfil an additional 2 theatre sessions within current medical staffing to improve performance to meet the national standard.

A trauma coordinator would support trauma planning and delivery. This role currently does not exist within NHS Fife and we remain the only mainland board who has not implemented this role. Options have been explored from within existing workforce and budget, with no immediate solution.

2.3.3 Financial

Cost for additional theatre and a trauma coordinator have been outlined in the action plan for the Trauma review process summary report presented to SLT.

2.3.4 Risk Assessment / Management

Given the lack of mitigation in relation to theatre capacity NHS Fife will continue as an outlier against the Scottish Hip Fracture Audit Standards.

Given this there is a high risk of patient harm due to delays to undergoing surgery. This risk will increase further given the projections of trauma numbers. This risk extends to all emergency trauma surgery, not just hip fractures

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

Trauma review process was a Multidisciplinary team process involving all key stakeholders. Output from the group reports to acute SLT and ASD CGC.

The Orthopaedic peer review process is a national process. External experts attend from peer boards, Scottish Government and relevant speciality organisations and reflects on

areas of excellence and areas for improvement. Part of this relates to trauma delivery with comparison to other similar boards.

2.3.8 Route to the Meeting

Via ASD CGC and Clinical Governance Oversight Group

2.4 Recommendation

The Committee is asked to take a **"moderate" level of assurance**.

The Committee is asked to **note** the following actions taken to improve access to trauma theatre for patients in Fife:

1. Completion of the Ortho trauma review process and development of an improvement plan
2. Work to improve theatre utilisation both within trauma and more generally
3. Movement of elective surgery to the QMH site
4. Completion of job planning to ensure consultant availability

Despite these actions, additional theatre staffing is required to ensure additional operating to both improve patient care and ensure compliance with the SNAP audit standard.

The Committee is also asked to **support** the need for additional resource to satisfy the need for additional theatre capacity.

The Committee is asked to **note** that further detail in relation to the costs associated with these additional sessions will be considered in a paper to be presented to the Executive Director Group meeting. The financial implication will be presented to a subsequent meeting of the NHS Fife Finance and Performance Committee.

Report Contact

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ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
22ND OCTOBER 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 22nd October 2024. This assurance statement summarises the key aspects of business covered.

	Summary	Assurance Level
1.	**NHS Fife Clinical Governance Oversight Group Terms of Reference**	Significant
	Terms of Reference was approved by the Group.	
2.	**SBAR NHS Fife Local Targets Sign-off Process**	Moderate
	Assurance was provided to the group on the sign off of the 15 quality performance indicator (QPI) targets within the Quality and Care section of the IPQR: • 3 QPIs have defined national targets (all Healthcare Associated Infections indicators; CDI, SAB, ECB) • 4 QPIs have locally defined targets with no national guidance (LAER/SAER actions, Pressure Ulcers and Stage 1&2 complaints) • 6 QPIs currently have no defined targets (number of major/extreme adverse events, Hospital Standardised Mortality Ratio and four mental health incidents) Assurance was provided in respect of the decision making of local targets where there is no national guidance.	
3.	**Adverse Events Improvement Plan Update**	Moderate
	Adverse Events Improvement Plan was presented and provides detail and progress on areas of improvement identified for 2024/2025, broadly these are: • Reporting; • Reviewing; • Learning and improving from adverse events; and • Improving support and engagement of patient/families and staff with the process. CGOG endorsed implementation of the revised trigger list and associated process changes from 6th January 2025.	
4.	**NHS Fife Patient Experience Flash Cards**	Moderate
	Assurance was provided to the group that: • Focused work on stage 1(S1) complaints has resulted in a significant reduction in the number of S1 complaints open • Stage 2 complaints - there has been a vast improvement of days taken to close a complaint from this time last year, from 94 days to	

	44 days. With 7 months performing above the median demonstrating an improvement. • "Acknowledged on time" (which sits within the Patient Experience Team) has remained at 100% for the last 3 months Other notable updates: • New Single Point of Contact (SPOC): Streamlines complaint handling process across Directorates. • Local Resolution Emphasis: Encourages resolving complaints directly to enhance patient satisfaction and reduce workload. • Dashboard Utilisation: Provides clarity on complaint status with further work required. • Promotion and Training: Regular support visits to clinical areas to encourage staff engagement with Care Opinion. • Volunteer Recruitment: Aiming to gather diverse Care Opinion patient stories, particularly from underrepresented groups.	
5.	**NHS Fife Health & Social Care Partnership Clinical Governance Assurance Report from 6th September 2024**	Moderate
	No matters were escalated to CGOG. The following key updates were provided: **Risk: Deep Dive Risk 10** An SBAR report was shared for assurance indicating that sufficient controls were in place for child and adult protection as evidenced by social work. The report indicated that there was ongoing work with the Executive Nurse Director to consider responsibilities and governance for health adult support and protection. **Inspections: Mental Welfare Commission (MWC) Visits** There was a MWC visit to Daleview (20th June), a regional low security unit for males with learning disabilities. The MWC recommendations focused on consistent care planning and meaningful activities; inspectors commented on the unit's impressive gardens. **Bairns Hoose Update (Assurance):** The Head of Service provided an update on the Bairns Hoose model which provides a child-centred approach to justice, care, and recovery for children who have experienced trauma, including victims or witnesses of abuse or violence, as well as those under the age of criminal responsibility whose behaviour has caused harm. The model supports children and young people. Fife was approved to lead the Pathfinder work. There was discussion around the funding for paediatric dietetic service. It was requested that a paper is presented at the next Clinical Governance Oversight Group meeting.	
6.	**Fife Acute Services Division Clinical Governance Assurance Report from 25th September 2024**	N/A
	This report is carried forward to December's meeting- no items escalated	

	verbally to the group. Medical Director requested that Stroke Audit Data which is routinely reported to the Acute Services Division Clinical Governance Committee should now also be presented at this group and the Board.	
7.	**NHS Fife Clinical Policy & Procedure Update**	Moderate
	The group were given assurance that they have a 98% compliance rate for all clinical policies and procedures overseen by the NHS Fife Policy and Procedure Group. Two policies are past their review with expectation to have these updated by the end of October 2024.	
8.	**NHS Fife Activity Tracker**	Moderate
	One new Consultation • Healthcare Improvement Scotland Standards for Maternity Care - Scoping Consultation Two Reports and Publications • Acute adult and older people hospital at home programme report 2023-24 • Quality of care review guidance: September 2024 New standard issued • Gender identity healthcare: Adults & Young People	
9.	**East Region Neonatal Services Draft Implementation Plan**	Limited
	The Minister for Public Health and Women's Health announced on 25 July 2023 the new model of neonatal care for Scotland. This means that care for babies born at less than 27 weeks, lighter than 800 grams or who are critically ill will have care provided by Neonatal Intensive Care Units (NICU) under a new networked model at Aberdeen Maternity Unit, (AMU) Edinburgh Royal Infirmary (ERI) and Queen Elizabeth University Hospital (QUEH). NHS Fife is an early adopter of "Best Start". The Associate Medical Director for Women and Children's Services outlined the concerns in relation to the proposed reduction of cots in NHS Fife. It is recommended that NHS Fife maintain the current capacity and cot designation until Spring 2025. The recommendation was supported by the group and it was noted that this has been escalated to the Clinical Governance Committee in November 2024.	
10.	**Mental Welfare Commission Investigation into Care & Treatment of Mr E**	Moderate
	In January 2024 the Mental Welfare Commission (MWC) published an investigation report in the care and treatment of Mr E, titled "They didn't ask me". The full report can be found on the MWC website at Investigation Mr E 2024.pdf (mwcscot.org.uk) The report identified significant issues in relation to legislation and integration of services. The MWC have highlighted numerous areas for improvement in HSCPs. An	

	analysis of structures and processes in Fife to 'benchmark' against the learning identified and recommendations made in the Mr E report, and then development of an action plan to address any local issues identified, was agreed as a beneficial response to the report. It was agreed that a there is a requirement to ensure that: • The learning from this report will be shared widely- with support from the Organisational Learning Leadership Group • A local action plan to address any issues identified locally would be developed	
11.	**NHS Fife Welch Allyn Project Update**	Limited
	Digital and Information were asked to support Proof of Concept (PoC) which connected Welch Allyn monitors to the existing Patientrack system. Wellch Allyn monitors enable the automatic transfer of patient observations onto Patientrack. This removes the need for transcription of observations, ensures timely logging of observations and removes risk of human error- improving the efficiency of taking observations. The additional benefit of this innovation is the time this releases for care. The evaluation of the PoC concluded it was successful with significant benefits delivered. Unfortunately following the PoC funding was not available to support further implementation or to keep the current system live. Therefore, a financial assessment is being undertaken and a paper will be submitted to appropriate committees regarding required and/or available funding. It was noted that this is a fundamental aspect of supporting the Deteriorating Patient work. The Medical Director gave full support for this progressing. It was requested that this must be aligned to those areas of most clinical need and that is a fundamental to the identification of deteriorating patients.	
12.	**NHS Fife InPhase Briefing**	Limited
	The proposed implementation of Inphase to replace Datix was presented. Inphase provides a full quality management system with functionality beyond what is currently provided on the current Datix system. It was a agreed that: • The Inphase Implementation Group Terms of Reference should be submitted to the next CGOG • The paper presented should be shared with EDG	
13.	**NHS Fife Medicines Safety Annual Report**	Moderate
	From April 2023- March 2024: • 1580 medication incidents were reported compared to 1466 the previous year • 72% of incidents were classed as "no harm" and 1.7% were classed as "major" • The top 3 types of incidents were related to: administration, prescribing and supply • Oxycodone (a high-risk pain medicine) is the most reported	

	medicine involved in incidents • Actions taken include – developing an attractive stock dashboard and attractive stock organisational action plan and producing educational resources to support staff Also noted: • The importance of the Medicines Safety Drumbeat which looks at all medication incidents for NHS Fife on a weekly basis was also highlighted- supporting identification of themes and reactive learning. • NHS Fife has a well embedded medicines governance structure to respond to and identify learning and actions from medication incidents. There is a multidisciplinary approach to medicines safety also substantial local expertise across professional groups in both reactive and proactive improvement approaches. The Medicines Safety work was commended.	
14.	**Linked Committee Minutes**	
	There were no escalations made to the Group	
15.	**Summary of Escalations to Clinical Governance Committee**	
	• East Region Neonatal Services Draft Implementation Plan NHS Fife • Fife Medicines Safety Annual Report • NHS Fife Adverse Events Improvement Plan	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Corporate Risks Aligned to the Clinical Governance Committee including update on Cancer Waiting Times Risk**
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 6 September 2024. The committee are asked to:

- note the corporate risks as at 18 October 2024 including the Cancer Waiting Times Risk 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 work on the Optimal Clinical Outcome risk continues.

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 6 September 2024.

The Committee is invited to:

- note the corporate risks as at 18 October 2024 including the Cancer Waiting Times Risk 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 work on the Optimal Clinical Outcome risk continues.

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:

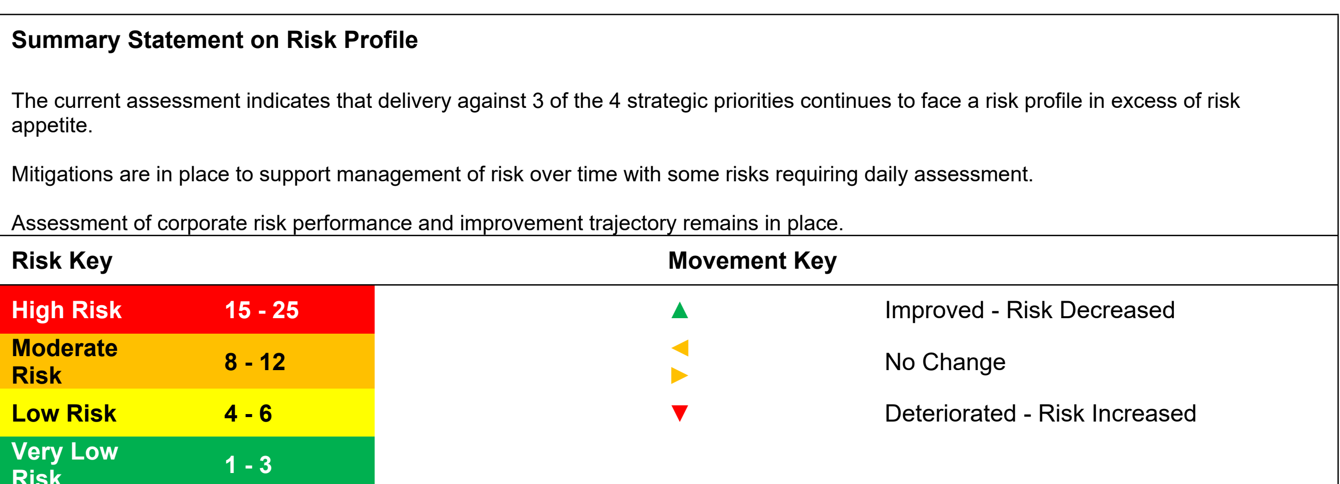
- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

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

Table 1: Strategic Risk Profile

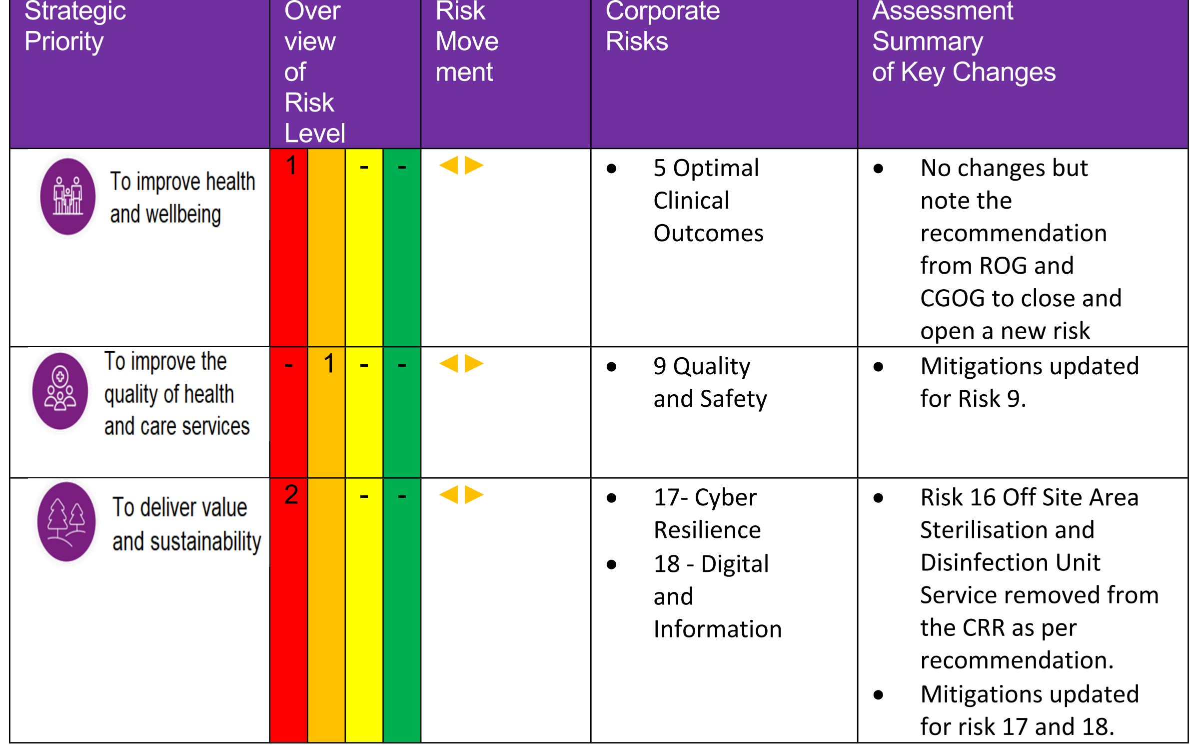
Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◄►	High
To improve the quality of health and care services	6	4	2	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	7	6	1	-	-	◄►	Moderate
Total	**20**	**15**	**5**	**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	Over view of Risk Level				Risk Move ment	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		-	-	◀ ▶	• 17- Cyber Resilience • 18 - Digital and Information	• Risk 16 Off Site Area Sterilisation and Disinfection Unit Service removed from the CRR as per recommendation. • Mitigations updated for risk 17 and 18.

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

- Four risks are now aligned to the Committee.
- Risk 16 on Area Sterilisation and Disinfection Unit Service has now been removed from the Corporate Risk Register as discussed previously.
- The risk level breakdown is now - 3 High and 1 Moderate
- Work continues on the reframing of an Optimal Clinical Outcomes risk.

Details of all risks are contained within Appendix 1.

Risk Updates

Following the closure of COVID 19 Pandemic Risk, a Deep Dive into future Pandemic Risk was presented to PH&WB committee on 9th September 2024. Oversight of this risk will be with the PH&WB committee.

Risk 5 - Optimal Clinical Outcomes

Further to discussion at EDG on the 5 September 2024 and this committee on the 6 September 2024 work continues on re-framing a new risk.

Risk 9 - Quality and Safety

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 to the Executive Directors in August 2024 and also shared at the Board development session in August 2024.

The intention is to redefine the risk beyond the process/governance focus that we currently have.

Risk 17 – Cyber Resilience

The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded for 2024. The compliance rate has increased to 93%, up from 77% from the previous year.

The action plan for improvement will be presented to the Information Governance and Security Steering Group for review and progress tracking. The associated and linked Risks for Cyber Resilience will be reviewed in line with the Audit report.

Risk 18 – Digital & information

A strategy completion report will be presented to the NHS Fife Board in November 2024.

A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment. The annual delivery plan for 2024/25 demonstrates an alignment to the RTP framework and continuation of required national and local digital programmes. A reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue)

The revised framework will include, financial and workforce planning, to support the mitigation associated risk.

Risk 8 – Cancer Waiting Times

The prostate cancer pathway remains the most challenging in terms of performance. The work of the Prostate Project Group continues with a review of the group itself to ensure appropriate buy in.

The Nurse-led model went live in August 2023 and has been very successful although there has been reduced activity recently due to training of a replacement staff member.

There was a focus on Transperineal (TP) Biopsy, the post MDT part of the pathway (outpatient appointment and oncology) and review of the robotic surgery capacity. TP biopsy waits have improved however the Post MDT part of the pathway (OPA and Oncology) together with robotic capacity remains a challenge.

There have been fortnightly meetings with Scottish Government (SG) and a quarterly monitoring of the Effective Cancer Management Framework. This is currently under review.

The work of the Single Point of Contact Hub (SPOCH) continues to effectively support initiation of the Optimal Lung Cancer and support the negative qFIT pathway. To remove patients from the lung pathway in a timely manner the Hub advises patients of 'good news'. The service has continued despite the having had both sickness and vacancy challenges. Support from Health Records has been received and has helped timely appointments for patients referred urgent suspected cancer.

The Cancer Framework is currently under review to ensure alignment with the Scottish Cancer Strategy. The Actions for 2024-25 are being agreed. A report highlighting the successes in year 1 and year 2 has been completed and taken to the Cancer Governance and Strategy Group and is due to be tabled at this Committee.

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.

Cancer Waiting Times funding will be provided on a recurring basis from 2024-25. Bids have been prioritised to support improvement.

Submitted bids against the 30M non-recurring funding have been successful for Q1 and Q2 and has now ceased. No further funding has been agreed. The focus of this funding was on diagnostics, treatment and backlog clearance.

ADP Actions for 2024/25 have been reviewed.

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 half (2) of the risks now within risk appetite for their respective domain. The other half (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 17 and 18 align to *Strategic Priority 4: 'To Deliver Value and Sustainability'.*
The Board has a Moderate appetite for risks in this domain.

- 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 18 October 2024
- Alistair Graham, Associate Director of Digital & Information on 18 October 2024
- Neil McCormick, Director of Property & Asset Management on 18 October 2024
- Dr Chris McKenna, Medical Director, on 18 October 2024
- Dr Joy Tomlinson, Director of Public Health on 18 October 2024
- Claire Dobson, Director of Acute Services on 18 October 2024

2.4 Recommendation

- **Assurance** - Members are asked to take 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

The following appendices are included with this report:

Appendix 1, NHS Fife Corporate Risks aligned to the CGC as at 18 October 2024
Appendix 2, Assurance Principles
Appendix 3, Risk Matrix

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Associate Director for Risk & Professional Standards
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NHS Fife Corporate Risk Register as at 18/10/24

No	Strategic Priority and Risk Appetite	Risk Title and Description	Mitigation	Risk Appetite Status	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
5	**HIGH**	**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.	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 5 September 2024 to close the risk and reframe. Work continues on the re-framing. 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. The governance arrangements supporting this work will inform the level of risk associated with delivering against	Within	High 15	Mod 10 by 31/09/24	◄►	Medical Director	Clinical Governance (CGC)

			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) 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.						
8	**MODERATE**	**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	**A paper was presented to the July FP&R meeting outlining the Planned Care Plan and the utilisation of funding.** The prostate project group continues with actions identified to improve steps in the pathway with a review of the group to ensure appropriate buy in. The Nurse-led model went live in August 2023 however there has been reduced activity due to training of a replacement staff member. There was a focus to look at the waits to TP biopsy, post MDT part of the pathway and review robotic surgery capacity.TP biopsy waits have improved however the Post MDT part of the pathway (OPA and Oncology) together with robotic capacity remains challenging. Fortnightly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer	Above	High 15	Mod 12 by 31/03/25	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			Management Framework is currently under review. Single Point of Contact Hub (SPOCH) continues to effectively support initiation of the Optimal Lung Cancer and support the negative qFIT pathway. To remove patients from the lung pathway in a timely manner the Hub advises patients of 'good news' albeit the service has had both sickness and vacancy challenges. Support from Health Records has helped timely appointments for patients referred urgent suspected cancer. The Cancer Framework is currently under review to ensure alignment with the Scottish Cancer Strategy. The Actions for 2024-25 are being agreed. A report highlighting the successes in year 1 and year 2 has been done and taken to the Cancer Governance and Strategy Group and is due to be tabled at Clinical Governance Committee 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. Cancer Waiting Times funding will be provided on a recurring basis from 2024-25. Bids have been prioritised to support improvement. Submitted bids against the 30M non-recurring funding have been successful for Q1 and Q2 and has now ceased. No further funding has been agreed. The focus of this funding was on diagnostics, treatment and backlog clearance. ADP Actions for 2024/25 have been reviewed.						

9	**MODERATE**	**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 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. Organisation Learning Group meetings have now been reestablished to continue this work. The intention is to redefine the risks relating to Quality and Safety beyond the process/governance focus that we currently have.	Within	Moderate 12	Low 6 by 31/03/25	◀▶	Medical Director	Clinical Governance (CGC)
17	**MODERATE**	**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 for 2024. The compliance rate has increased to 93%, up from 77% from the previous year. The action plan for improvement will be presented to the Information Governance	Above	High 16	Mod 12 by 30/09/24	◀▶	Director of Digital and Information	Clinical Governance (CGC)

			and Security Steering Group for review and progress tracking. The associated and linked Risks for Cyber Resilience will be reviewed in line with the Audit report. Management actions continue to be progressed.						
18	**MODERATE**	**Digital & Information** 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.	A strategy completion report will be presented to the NHS Fife Board in November 2024. A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment. The annual delivery plan for 2024/25 demonstrates an alignment to the RTP framework and continuation of required national and local digital programmes. A reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue) The revised framework will include, financial and workforce planning, to support the mitigation associated risk.	Above	High 15	Mod 12 30/04/25	◄►	Director of Digital and Information	Clinical Governance (CGC)

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

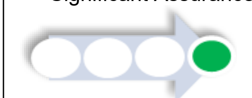
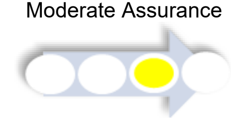
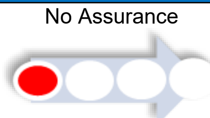
General Questions:

- 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:

Significant Assurance	Moderate 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
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**			**Deferred to next mtg**	✓	

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**	**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**				**Deferred**	✓	
Medicine 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~~ **cancelled**	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	07/03
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	06/03
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**	Removed from workplan – Training & Exercise plan was presented to the Resilience Forum.					

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)*	**Medical Director**				✓		
Neonatal Mortality Review Health Improvement Scotland Report	**Medical Director**			✓			
St Andrews Community Hospital Security Breach Update & Action Plan	**Director of Finance & Strategy**			✓			
Response to National Oncology Review	**Medical Director**					TBC	
Business Transformation RTP (from a clinical aspect)	**Medical Director**					✓	
Adverse Events Improvement Plan Update	**Associate Director of Quality & Clinical Governance**				✓		
Digital Strategic Framework Timeline Update	**Director of Digital & Information**				✓		

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**			✓			

Matters Arising (cont.)							
	Lead	**03/05/24**	**12/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Reform, Transform, Perform – Transforming Urgent Care	**Director of Acute Services**			✓ Private Session			
East Region Neonatal Services	**Medical Director**				✓		
Orthopaedic Hip Fracture Audit	**Medical Director**				✓		
Development Sessions							
	Lead						
Principles of Clinical Governance	**Medical Director**	**07/05/24**					
The Patient Rights Directions.	**Director of Nursing**				**22/11/24**		

NHS Fife

Meeting: Clinical Governance Committee

Meeting date: 1 November 2024

Title: Annual Delivery Plan 2024/25 Q2 Report

Responsible Executive: Margo McGurk, Director of Finance & Strategy

Report Author: Susan Fraser, Associate Director of Planning & Performance

Executive Summary

This report contains quarter 2 update on progress for Annual Delivery Plan (ADP) 2024/25.

There are 87 deliverables aligned to Improve the Quality of Health and Care Services Strategic Priority. As of the end of Sep-24 (quarter 2 of 2024/25), there is four that are **'complete'** with majority of deliverables (66.7%/58) being **'on track'**. Additionally, there are 24 deliverables that are **'at risk'** with one that is **'unlikely to complete on time/meet target'**.

Summary of status of all deliverables in ADP displayed below, Total includes deliverables that cover multiple Strategic Priorities.

Strategic Priority	Unlikely to complete on time	At risk	On track	Complete	Suspended /Cancelled	Total
Improve Health and Wellbeing	2	9	22	1	1	35
Improve Quality of Health and Care Services	1	24	58	4	-	87
Improve Staff Experience and Wellbeing	-	5	16	-	-	21
Deliver Value and Sustainability	6	12	40	2	-	60
Total	**9**	**50**	**138**	**7**	**1**	**205**

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 paper presents the final Annual Delivery Plan 2024/25 and accompanying approval letter from the Scottish Government to the NHS Fife Board for final approval

2.2 Background

The Delivery Plan guidance was issued alongside the NHS Scotland Financial Plan 2024/25 Guidance and the two have been produced in conjunction.

The planning priorities set out in this 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 ten 'Drivers of Recovery', which will be used to frame planning 2024/25, have remained broadly in line with those used in 2023/24.

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

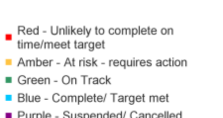
2024/25 Quarter 2 Update

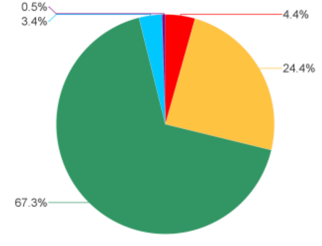
There are now **205** deliverables incorporated in ADP for 2024/25 across both NHS Fife and Fife HSCP. There are a number of deliverables carried over from 2023/24 as well as those relating to RTP. Additionally, there are 42 deliverables that are not aligned to a Recovery Driver.

Recovery Driver	n=163
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	27
7. Women & Children Health	13
8. Workforce	18
9. Digital & Innovation	21
10. Climate	13

Strategic Priority	n=205
All	2
Improve Health and Wellbeing	35
Improve the Quality of Health and Care Services	86
Improve Staff Experience and Wellbeing	21
Deliver Value and Sustainability	60

As of end of Sep-24 (Quarter 2 of 2024/25), there ar**e seven** deliverables that are **'complete'** with most **(67.3%/138) 'on track'**. There are nine deliverables that are **'unlikely to complete on time/meet target'**. There is also one deliverable that has been **'suspended/ cancelled'**.





There are 87 deliverables aligned to Improve Quality of Health and Care Services Strategic Priority. Details for deliverable that is **'unlikely to complete on time/meet target'** is below**.**

Deliverable	Comment
Development of a new OP specialist Gynaecology Unit	All capital projects are on hold.

Listed below are the deliverables **'at risk'** at quarter 2 than were 'on track' at quarter 1, as well as those that were **'complete'** or **'suspended/ cancelled'** during quarter 2.

Deliverable	
At risk – requires action	
	Community Rehab & Care: To develop a modernised bed base model in Fife that is fit for the future.
	Develop and scope an SDEC model of care to support same say assessment and increase our ambulatory models of care.
	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.
	Digital / Scheduling: create a centre of excellence for scheduling across community services
	Forensic Mental Health services are reviewed and restructured to ensure appropriate pathways that enable patient flow and maximise rehabilitation and recovery.
	MAT based outcomes embedded in all ADP service level agreements. The standards implemented and fully maintained and PHS assessment supports this.
	Rheumatology workforce model redesign.
	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
	Targeted actions to improve the quality of our Immunisation services

	Translation and implementation of agreed Business case Options for Co-badged Clinical Trials Unit/ Clinical Research Facility with University of St Andrews
Complete	
	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.
	Implement national Excellence in Care (EIC) objectives within NHS Fife In line with 3 Year strategy, embed in Fife by 2025.

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 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 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 17 October 2024

2.4 Recommendation

This Committee are asked to:

- **Assurance** – this report provides a **“moderate”** level of assurance.
- **Endorse**– Endorse the ADP Q2 return for formal approval at the NHS Fife Board and for submission to Scottish Government.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Fife ADP 2024/25 Quarterly Report Q2

Report Contact
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Planning and Performance Manager
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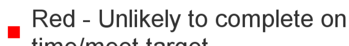
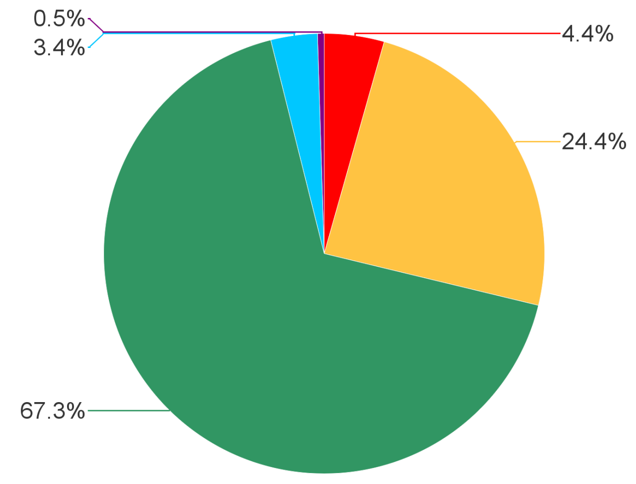
Annual Delivery Plan 2024/25 - Q2 Progress Summary

Q2 Status	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met	Purple - Suspended/ Cancelled	Total
1. Primary and Community Care	1	8	13	1		**23**
2. Urgent and Unscheduled Care	2	6	7			**15**
3. Mental Health		5	11	2		**18**
4. Planned Care			9			**9**
5. Cancer Care	1	1	4			**6**
6. Health Inequalities		7	18	1	1	**27**
7. Women & Children Health	2	5	5	1		**13**
8. Workforce		2	16			**18**
9. Digital & Innovation	1	8	12			**21**
10. Climate		2	11			**13**
Other	2	6	32	2		**42**
To Improve Health and Wellbeing	2	9	22	1	1	**35**
To Improve the Quality of Health and Care Services	1	24	58	4		**87**
To Improve Staff Experience and Wellbeing		5	16			**21**
To Deliver Value & Sustainability	6	12	40	2		**60**
ALL			2			**2**
Total	**9**	**50**	**138**	**7**	**1**	**205**





Annual Delivery Plan 2024/25 - Q2 Progress Summary

RTP - Re-form, Transform, Perform

Deliverable	Directorate	2024/25 Q2 Comment	2024/25 Q2 Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Business Transformation	Digital	Bridging actions identified Mid Year review being completed	PID Approved Agreement of workforce mechanisms to support transformation Further development of digital solutions planning Establishment of programme to support project delivery (co-ordination of digital enablers and delivery of direct impact projects, including work on a new model for 'administration services'	To Deliver Value & Sustainability	**Red - Unlikely to complete on time/meet target**	**Red - Unlikely to complete on time/meet target**
SLA and External Activity	Finance & Strategy	Whilst there is ongoing review of the data to establish opportunities, there is national discussion on SLA potential uplifts through FLG, CFN and DOFs. There is likely to be a separate DOF session to further discuss with a view to achieving resolution.	Ongoing review of data to help establish opportunities for repatriation and identify reasons for inappropriate referrals to other boards Ongoing development of Performance Management group and subsequent arrangements with NHS Lothian and NHS Tayside	To Deliver Value & Sustainability	**Red - Unlikely to complete on time/meet target**	**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	Supported Discharge Units implemented in July however due to continued increased demand occupancy has remained at over 100% of agreed 30 beds. Locum surge Consultant remains after a review with Clinical leads. Gateway Dr's & JCF's supporting 6&9 and surge model.	Reduction of Ward 9 to 11 beds and associated maintenance of new footprint Launch of Supported Discharge Units Awareness Raising Programme of Discharge Planning & Surge Review of Locum Surge Consultant post	To Deliver Value & Sustainability	**Red - Unlikely to complete on time/meet target**	**Red - Unlikely to complete on time/meet target**
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation	Workforce	We continue to onboard staffing groups beyond nursing as we move to a staff bank however we do not have the financial envelope to consolidate all local banks as this time. There fore there is a risk this is not delivered by March 2027.	Continue implementation of Direct Engagement under RTP and then transition of medical locums into Staff Bank	To Deliver Value & Sustainability	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Digital & Information Projects	Digital	Ongoing	Assess Benefits for Quarter	To Deliver Value & Sustainability	**Green - On Track**	**Amber - At risk - requires action**
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets	Pharmacy & Medicines	The Board is ahead of previous years in delivery of medicines efficiencies work. However, the scale of targets this year is high and there are challenges in securing full delivery. Significant engagement work across sectors and MDT is ongoing. The medicines waste campaign has been launched	Formal launch of medicines waste campaign for the public and staff, to reduce medicines waste and volume of prescribing. Ongoing delivery of Medicines efficiencies plans across Acute services and HSCP, aligned to 15 box grid.	To Deliver Value & Sustainability	**Green - On Track**	**Amber - At risk - requires action**

Deliverable	Directorate	2024/25 Q2 Comment	2024/25 Q2 Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Estates Rationalisation	Property & Asset Management	Work has progressed with the closure of HH and Cameron House and Haig House. Staff have moved into Fife Council (Fife House and Bankhead) Cameron phased decants are underway as planned and on track. Site plans for Stratheden and discussions with Fife Council are underway and on track	VHK E&F/L8 bookable desks works Identify further hot desk hubs Cameron alternative clinical area identified for displaced team Fife Council solutions in place (Fife House & Bankhead) including IT Cameron phased decants Site consolidation/disposal plans further developed	To Deliver Value & Sustainability	Green - On Track	Green - On Track
Infrastructure - Workforce	Digital	Completed work for Cameron	Decommission Cameron Establish other hotdesking locations	To Deliver Value & Sustainability	Green - On Track	Green - On Track
Non-compliant Rotas	Medical Directorate	Assurance remains as moderate due to controls put in place at service level to encourage rota compliance. Rota monitoring began in September 2024. A second stage of monitoring will be completed from February 2025 with final savings being reported at the end of the financial year.	Approve SOPs/escalation process Approve and distribute new induction packs and implementation Approval of Wellbeing comms Potential Doctors mess redesign Rotas go live, monitoring to commence Communications strategy for new DDiT & Gateway EU live Rota monitoring begins	To Improve the Quality of Health and Care Services	Green - On Track	Green - On Track
Procurement Savings within Acute Services	Acute Services	21 schemes in progress, In year on track for 79%/ FYE will be 88% of target: -2 cost avoidance (not included in target savings) -9 underway -4 due to commence Sept. -2 awaiting approval -4 having logistics worked up 11 other schemes in initial development. The aim is that these 11 will close the gap in the current in year impact forecast. Continued risk that objective will not be reached but continued activity to identify opportunities to mitigate this risk. Assurance is moderate.	Ongoing reviews of expenditure and savings opportunities.	To Deliver Value & Sustainability	Amber - At risk - requires action	Green - On Track

Annual Delivery Plan 2024/25 - Q2 Progress Summary

To Improve Health and Wellbeing

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Increase capacity for providing in-hours routine and urgent dental care	1.5	The PDS cannot influence Dental registration in Fife, however we continue to provide targeted and emergency treatment appointments for patients. We work closely with the Scottish Government to have a collaborative approach to Dental body corporates. Ensure SDAI grants are available to GDP's in the areas of greatest need.		1. Primary and Community Care	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Children's speech, language and communication development Plan		Work with Health Promotion has not been a focused priority due to other pressures in both services. Although relevant strategic strands have been identified, SLT colleagues have not yet been informed of the forums that exist and how to start to engage with others to develop a plan.		7. Women & Children Health	Green - On Track	Red - Unlikely to complete on time/meet target
Deliver a more effective BCG and TB programme. Public Health Priority 1 and 2		National discussions ongoing to scope Public Health response	No further progress from Q1		Amber - At risk - requires action	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)		A delivery plan for Fife has been developed, due to be reviewed and agreed by End of October. Task Group for HCV elimination in Fife has not yet been reestablished due to operational/workforce pressures. SG expectation is for elimination by March 2025. Finance & resource dependencies being considered as available budget insufficient to meet in year target.		1. Primary and Community Care	Amber - At risk - requires action	Amber - At risk - requires action
Improved Fife-wide ADHD pathways for children & Young people	7.1	Due to a change in Children's Service Manager in the H&SCP and also the lead for the ADHD review, there has been no further progress or update provided. It is hoped this will recommence as soon as possible.		7. Women & Children Health	Amber - At risk - requires action	Amber - At risk - requires action
National - Child Health Replacement	9.1	Await delivery via National Teams		9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 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	Initial application decision expected 03.10.2024 with final decision 03.11.2024.	Contributing to Fife housing partnership ending homelessness together priority group pathways. Contributing to opportunities Fife partnership priorities. Contribute to Fife Partnership Board review of Fife strategic assessment and opportunities for collaborative working and using the Marmott principles. Application submitted for the Institute of Health Equity and Public Health Scotland Collaboration Programme using the Marmott Principles.	6. Health Inequalities	**Amber - At risk - requires action**	**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	Proposed new 'transformation oversight group' structure approved within 2024 - 2027 Immunisation Strategic Framework submitted to Public Health & Wellbeing Committee 01/07/24. This will bring together inclusion and quality improvement work and report into CIS programme board. Improvement activity groups for childhood, teenage & adult programmes to sit under this oversight group. Limited capacity from service nursing leads to engage over Autumn /Winter programme may delay progress. Paper brought to CIS programme Board on 01/10/24 outlining position.		1. Primary and Community Care	**Green - On Track**	**Amber - At risk - requires action**
Refreshed Mental Health and Wellbeing Strategy for Fife for 2023 - 2027	3.2	The aim is to take the strategy to IJB within 3rd quarter and will align with the national strategy. The working group has been established and work is ongoing.	Work on the draft strategy will continue, this will include a review of the draft strategic priorities to ensure alignment with identified issues and challenges.	3. Mental Health	**Green - On Track**	**Amber - At risk - requires action**
Review existing wellbeing indicator collection data to develop multi-agency response in line with GIRFEC framework.	7.1	The refreshed National CP Guidance has meant that all processes within multi agencies have had to be reviewed and streamlined. This is transformational change and has required extensive work to put in place. we envisage all pathways to be completed and full guidance implementation by Dec 24.		7. Women & Children Health	**Green - On Track**	**Amber - At risk - requires action**
Specialist clinic provision to increase by 25% in our most deprived areas with a view to achieving 473 quits in FY 20024-25 Increase targeted Very Brief Advice (VBA) information sessions by 25% Fife wide to include mental health in patient sites. Establish a drop in and bookable clinic within maternity units to receive as early as possible referrals for maternity clients. Create referral pathway for in patient discharge on an opt out basis		Clinic provision running at 45 clinics per week. Q1 data 85% of LDP Standard. We have progressed this work on target with provision of stands as planned.	Weekly Outreach work in identified localities of deprivation and need. Work continues to develop a robust referral pathway to the service from across the FHSCP, acute & primary services. Referrals from maternity services for pregnant smokers has remained steady, there are currently 42 active caseloads for pregnant smokers, weekly clinics in the VHK maternity unit.	1. Primary and Community Care	**Green - On Track**	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Deliver the child aspects of Fife Annual Poverty Plan with Fife Council and other partners.	7.3	Confirmation of successful bid to Child Poverty Accelerator Fund which will enable expansion of income max referral pathway across child health services with a focus on children with a disability. This work is being progressed by short life working group.	Identify funding source to continue NHS actions including income maximisation for pregnant women and parents of under 5s beyond Sept 2024; explore expansion to community child health services, bid submitted. Influence NHS Fife Anchor Strategy to focus ambitions relevant to child poverty	7. Women & Children Health	**Amber - At risk - requires action**	**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	Work continues on the development of Clinical Pathways and achieving the National CAMHS spec.		3. Mental Health	**Green - On Track**	**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	Ongoing recruitment continues to ensure the service is fully staffed. The Early Intervention Service continues to ensure children and young people receive the right intervention at the right time and by the right people. The focus groups continue to be developed and will be rolled out in due course. The service has recently reviewed its RTT trajectory and introduced improvements to ensure it meets and sustains RTT by February 2025.	Maintaining early intervention services to ensure young people who require specialist CAMHS can achieve timely access Ongoing recruitment to ensure workforce is at full capacity Fife CAMHS Early Intervention Service will develop a Parent and Carer Focus Group to identify areas of improvement to better meet the needs of families in Fife prior to referrals being made.	3. Mental Health	**Green - On Track**	**Green - On Track**
Child and Adult weight management programmes: Develop a sustainable workforce within the resources available via regional funding award	6.3	Work remains on track to achieve our milestones outlaid in Q4 for 2024/25		6. Health Inequalities	**Green - On Track**	**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	Contributed to End of Yr 2/Programme End Report which was received favourably at governance groups. Attended 2nd meeting of new HRPM Safety Group, contributed to discussions re dissemination of Programme End Report, ongoing EQIA requirements for HRPM work and prioritisation of future areas of work of group, including ways to demonstrate impact	Provide public health perspective on HRPM Safety Group Advise and support evaluation aspects of HRPM work	6. Health Inequalities	**Green - On Track**	**Green - On Track**
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.		The Public Health Intelligence Team has continued to undertake work across all priorities including work on children and young peoples health and wellbeing, infant feeding and alcohol and drug related hospital admissions.	Lead or collaborate on work across all six Public Health priorities and ensure outputs from this work are produced to agreed timescales and standards and disseminated in a range of formats as appropriate.	6. Health Inequalities	**Green - On Track**	**Green - On Track**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
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	The safety programme is progressing as planned, with key groups and engagement in place. The annual report is currently going through governance committees.	Continuing to ensure safety groups have focussed delivery of agreed objectives. Establishment of owners within MDT to broaden buy-in and drive. Continued development of engagement report Board development session on meds safety to be delivered Annual report progressing through governance committees for review	6. Health Inequalities	Green - On Track	Green - On Track
Develop and Enhance Children's Services		Phase 2 IRD health operating model pilot PDSA completed, final phase commenced. Project team established to progress phased approach to health raised IRDs. Multi agency GIRFEC Guidance Training through PDS (Funded through WFWF). Child Wellbeing Pathway Implementation Group established to lead on the CWP refresh which aligns to the GIRFC refresh. UNCRC Incorporation Act becomes law in July 2024. Merging of health care and care experience community group with the Promise SLWG to progress the Promise work in NHS/HSCP Fife. Promise Plan 24-30 published by SG and being discussed at HC & The Promise merged group.	Continue Roll out of multiagency training (GIRFEC)	7. Women & Children Health	Green - On Track	Green - On Track
Development of improved digital processes i.e. online pre-employment and management referral programmes.		COHORT upgrade in progress.	Consideration and development of options for OH system procurement in line with current system contract expiry.	8. Workforce	Green - On Track	Green - On Track
Ensure effective coordination and governance for adult screening programmes in Fife		The Cervical Exclusion Audit - review of all 10,409 records is complete and all participants have received letters about the audit outcome. Follow up clinics at Primary Care and Gynaecology are still ongoing. Ongoing work to recruit staff to deliver the Inequalities Action Plan and the Bridging the Gap Project.	Investigation and management of screening programme incidents and adverse events, including the National Cervical Exclusion Audit.	6. Health Inequalities	Green - On Track	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.		Review of vaccine preventable disease and uptake data as per annual workplan at Area Immunisation Steering Group (AISG) meeting on 03/06/24. AISG Annual Assurance statement submitted to Public Health Assurance Committee at meeting 12/06/24. Annual Immunisation Report submitted and presented at Public Health & Wellbeing Committee on 01/07/24 along side refreshed Immunisation Strategic Framework 2024 - 2027.	Submission of Annual Immunisation Report. Refreshed 2024-2027 Immunisation Strategic Framework. Submission of AISG annual assurance report to Public Health Assurance Committee.	6. Health Inequalities	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
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	EDG paper prepared on future OH Service delivery.	Review and retention of bank and admin fixed term contracts Review of OH provision as part of Directorate service change proposals completed, taking account of succession planning, service resilience and diversification of service provision to support staff health and wellbeing within NHS Fife Examine the effects of diversification of service provision and implications on OH Team resources Consultation on model of OH Service delivery ongoing	8. Workforce	Green - On Track	Green - On Track
Home First: people of Fife will live long healthier lives at home or in a homely setting	2.6	Home First Strategy Delivery Plan 2024-2025 has received Committee(s) approval; delivery plan also includes progress against 2023 deliverables. First Annual Report for the Home First Programme was submitted to Committee(s) in summer 2024.		2. Urgent and Unscheduled Care	Green - On Track	Green - On Track
Improve access for patients and carers through improved communication regarding transport options	1.7	A new NHS Fife/HSCP community transport leaflet has been produced. A refresh of the NHS Fife/HSCP travel expenses leaflet has been completed. Both leaflets are being promoted and distributed through a range of networks and are on NHS Fife and HSCP webpages. Progressing work on gathering data on travel claims.	Transport information and resources available and a system in place to measure uptake .	1. Primary and Community Care	Green - On Track	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	During Q2 Locality Planning Groups and short life work groups continue to manage and execute the 7 locality delivery plans. Below highlights projects that started/finished in Q2. •Ongoing monitoring and evaluation of the KY Clubs – supporting people affected by alcohol and drug harm (Kirkcaldy and Cowdenbeath) •Home First – weekly verification to review patients with 2+ admissions or 3+ attendance to A&E in the previous 12 weeks (Levenmouth). The data collection for the ToC end 24th Sept. •Mental Health Response Car – test of change commenced in the Levenmouth Locality on 7th June for 6 months. •Local Development Officers continue to monitor the projects awarded funding from the Unpaid Carers Community Chest fund (Fife wide). •Falls Prevention initiative in partnership with Mobile Emergency Care Service and Community Safety completed test of change (Dunfermline) – recommendation to extend the pathway Fife wide.	Establish short life working groups to manage and execute the 7 locality delivery plans. Monitor and evaluate the round 1 of the community chest applications (fund for unpaid carers). Co-ordinate and facilitate the 7 locality meetings in September - review and update delivery plans.	6. Health Inequalities	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
New risks identified through this surveillance by urgently convening incident meetings to evaluate the risks and agreeing shared actions. The results of these meetings can be quickly cascaded to networks of people who are able to intervene – frontline workers, peer networks and individual people who use drugs can be provided with information on the risks and advice on how to keep as safe as possible	6.2	On Track Group has been established and approved by the ADP Committee. TOR in place, chair appointed, process tested and approved in line with PHS guidance	Establish stand up ADP subgroup with TOR and reporting governance to ADP Committee Monitor process for efficiencies Manage action planning and implementation group	6. Health Inequalities	Green - On Track	Green - On Track
Public Health Priority 4: National Drugs Mission Priorities; MAT treatment standards; Fife NFO strategy; Fife ADP strategy	6.2	Public Health continues to provide support to the ADP on alcohol and drugs issues including in the implementation of the ADP Annual Delivery Plan, mapping the provision of alcohol services in Fife and the redesign of pathways into, through and out of residential rehabilitation. The purpose of the multi-agency exercise was to ensure system resilience in the event of an emergency involving unknown potent substances in the community.	Provide public health advice on alcohol and drugs to support Fife ADP and other colleagues. Contribute to the implementation of the National Drug Mission Priorities, MAT treatment standards and the ADP 2024-2027 strategy and delivery plan as required. Continue to advocate for prevention and early intervention. A multi-agency suspected drug related mass casualties incident exercise was held in late August 2024.	6. Health Inequalities	Green - On Track	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	Working groups of Food4Fife partnership have developed action plans and are implementing them. Partnership awarded Silver Sustainable Food Places Award for the Food4Fife Strategy. Community Planning partners met with Public Health Scotland and agreed systems approach to physical activity to be adopted in Fife.	Priority actions from the food strategy delivery plan to be agreed. Partnership approach to physical activity being developed with public health Scotland	6. Health Inequalities	Green - On Track	Green - On Track
To embed a working business continuity management systems process that is measurable and able to be easily monitored.		BCMS dashboard is monitored by resilience team. A resilience co-ordinator job recruitment is confirmed as now approved, this will support the resilience BCMS & reporting needs.	Compliance and performance metrics is reported quarterly through the Resilience Forum	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track
Work with local authorities to take forward the actions in their local child poverty action report	7.3	Confirmation of successful bid to Child Poverty Accelerator Fund which will enable expansion of income max referral pathway across child health services with a focus on children with a disability. This work is being progressed by short life working group. Monitoring of income maximisation pathway - MW, HV, FNP, CARF		7. Women & Children Health	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Work with partners to increase efforts to reduce the impact of climate change on our population.		Invitations have been issued for interest in Sustainability Ambassador forum. Until interest is expressed and reviewed, this element will not progress. Early actions have been taken this quarter. Continuing to support our planning colleagues to review and submit health elements of the LDP evidence report. The evidence report is required to progress with "The place matters call".	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	Green - On Track
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	Achievement of Disability Confident level 3 status Work ongoing to progress with employability programmes - making focus on developing the young workforce and exploring links to scope engagement making a focus on child poverty and the priority groups and areas of multiple deprivation Employability engagement sessions planned for September 2024 and Feb/March 2025 targeting high school pupils Continue working in collaboration with Fife College to progress EMERGE initiative. Explore routes and links to promote Community Benefits Portal NHS has partnered with MCR Pathways to support care experienced and vulnerable young people to realise full potential through education Roll out Life Chances initiative with Fife Council, develop Armed Forces Talent Programme	Continue to scope out opportunities whilst working through NHS Anchor strategic objectives to build upon our AI workplan. 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. 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, this event is likely to be into 2025	6. Health Inequalities	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 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	The Fife ND service has recently rolled out a new service design. This is not yet fully operational as requiring to respond and adapt to initial issues.	Co-produce and deliver pre and post diagnostic support to children, siblings and families Fully operationalise Triage model aligned to National ND Specification Implement neurodevelopmental pathway, combining existing Neurodevelopmental teams to embed a single point of access for NDD Fife CAMHS and partner agencies will work towards achieving the standards set out within the National Neuro-developmental Specification. This will be achieved through the reallocation of and streamlining existing assessment pathways and the implementation of learning from partnership test of change to co-produce delivery of pre and post diagnostic support to children, young people and their families.	3. Mental Health	Green - On Track	Blue - Complete/ Target met
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	Due to funding restrictions this deliverable cannot be achieved. However additional one stop shop in Kirkcaldy launched and has evaluated well. This will continue and has been sustained by a grassroot organisation	Set up SLWG to focus on locality based approaches for alcohol and drug use in the Glenrothes area with support from locality and community workers, lived experience and ADP commissioned services Project plan development for KY Glenrothes Assessment of additional Kirkcaldy locality one stop shop to be conducted and hand over to grassroot organisation to continue delivery	6. Health Inequalities	Green - On Track	Purple - Suspended/ Cancelled

To Improve the Quality of Health and Care Services

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Development of a new OP specialist Gynaecology Unit	7.2	All capital projects are on hold.		7. Women & Children Health	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets - Stage 1		There are a number of delayed Stage 1's within in the system Concentrated focus on reducing all Stage 1's that are over 10 days. New system to ensure all Stage 1's without consent are closed on day 11. Concentrated focus on ensuring there is a greater uptake from Services to close Stage 1's through local resolution.			Red - Unlikely to complete on time/meet target	Amber - At risk - requires action
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets - Stage 2		PET and services have agreed to temporarily pause weekly complaint meetings to focus on more timely updates and escalation of Stage 2 complaints. Commence data collection within PET to review the length of time taken to draft a response letter and to focus on improvement work. This should be completed within 5 working days.			Red - Unlikely to complete on time/meet target	Amber - At risk - requires action
Continue to deliver the Community Listening Service.		Discussions ongoing within Directorate as to possible solutions to ensure service is maintained	Review impact of withdrawing service in light of financial constraints of continuing coordinator role. Review possible avenues how any possible gap can be filled	8. Workforce	Amber - At risk - requires action	Amber - At risk - requires action
Contribute Public Health perspective and evaluation support to Fife's Mental Health Strategy Implementation Group.		Work on finalising the Mental Health & Wellbeing Strategy has re-started and contributions from PH perspective have been incorporated into draft Strategy and accompanying EQIA. Mental Health SIG still to be re-established and PH representation on this and advisory role into the evaluation framework will recommence once this group starts to meet again and Mental Health & Wellbeing Strategy is approved.	Attended meetings of Mental Health & Wellbeing Strategy Working Group Provided PH perspective on draft Mental Health & Wellbeing Strategy Provided PH perspective on EQIA for strategy	3. Mental Health	Amber - At risk - requires action	Amber - At risk - requires action
Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences		Awaiting a meeting to discuss and plan a lived experience group.			Amber - At risk - requires action	Amber - At risk - requires action

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Digital / Scheduling: Digital systems will be enhanced to realise full potential of integration across health and social care	2.1	Life Curve App to be further rolled out across Fife. Perusing ReSPECT. Scottish Government removing funding and currently arranging a meeting with SG to look at options. Ongoing discussions with digital colleagues in regards to potential solution (To support SPOA). Feasibility study almost complete and this will inform next steps.		2. Urgent and Unscheduled Care	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Expand on current system wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models	2.1	Advanced plans to test Urgent care hub within a Cluster, plans to be agreed at end of Quarter 4. Initial plans presented and endorsed by GMS implementation Group Sept 2024.	Clearly agree scope and ambitions from this work; identify potential test initiatives	2. Urgent and Unscheduled Care	**Amber - At risk - requires action**	**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	Test of 'waiting well' approach commenced in AMH Psychology	Begin testing a 'waiting well' approach to improve the experience of people who have to wait for PT. Review supervision and support for other services and agencies to increase access to high-quality interventions. Scope options for 3rd and Independent Sector commissioning to support delivery.	3. Mental Health	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Implement IP Workforce Strategy 2022-24		Working Together engagement event re-arranged for October 2024. Ongoing collaborative working for a whole system approach to infection prevention continues through LISDP. Progress of delivering strategy must be considered in line with RTP and available resources.	Continue bi-monthly LISDP Steering Group meetings HAI-Executive, ICM and ICD to attend CNOD "Working Together" engagement event	1. Primary and Community Care	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Implement new referral management and electronic patient records system (TrakCare/morse) within P&PC Physiotherapy service.		Transition to new systems are now in the preparatory phase with forms being streamlined and templates being created, however at this stage D&I have not yet been able to give a definitive transition and 'go live' date. Q2 milestones moved forward to Q4 instead.		1. Primary and Community Care	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Implement preventative podiatry service in care homes		We have recruitment challenges in Podiatry, limiting our workforce to deliver on this milestone.		1. Primary and Community Care	**Amber - At risk - requires action**	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
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	Ongoing review of roles, especially epilepsy in view of the difficulty recruiting to the B6 post. Job evaluation is required.	Ongoing review of specialist services required. Epilepsy B6 out for recruitment, but may require an amended JD to go through job evaluation for consideration at B7.	7. Women & Children Health	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Support the creation of Person Centred Care Planning Principles		Challenges due to clinical pressures			**Amber - At risk - requires action**	**Amber - At risk - requires action**
Community Rehab & Care: To develop a modernised bed base model in Fife that is fit for the future	2.6	Progress has slowed in order to align with Acute Services.		2. Urgent and Unscheduled Care	**Green - On Track**	**Amber - At risk - requires action**
Develop and scope an SDEC model of care to support same say assessment and increase our ambulatory models of care.	2.2	Awaiting approval by EDG and NHS Fife Board- not approved at first submission. From August new model redesigned and remains in development. Acute Medical Recruitment unsuccessful for new consultant post. Work progressing to schedule unscheduled care.		2. Urgent and Unscheduled Care	**Green - On Track**	**Amber - At risk - requires action**
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	Children's Services is developing a data dashboard to ensure visibility of all relevant multi-agency data, which will be used to inform KPIs and measure progress.		7. Women & Children Health	**Green - On Track**	**Amber - At risk - requires action**
Digital / Scheduling: create a centre of excellence for scheduling across community services	2.6	Ongoing discussions with digital colleagues in regards to potential solution. Feasibility study almost complete and this will inform next steps.		2. Urgent and Unscheduled Care	**Green - On Track**	**Amber - At risk - requires action**
Forensic Mental Health services are reviewed and restructured to ensure appropriate pathways that enable patient flow and maximise rehabilitation and recovery.	3.4	Specification shared with MDT. Meeting requires to be held with MD which will inform workforce. Competing demands have delayed same. Will recover in Q3	MDT to Scope clinical demand to review / refine service specification to inform workforce. Pathways meeting o be held with MDT	3. Mental Health	**Green - On Track**	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
MAT based outcomes embedded in all ADP service level agreements. The standards implemented and fully maintained and PHS assessment supports this	6.2	MAT 3 could not be reviewed and other provision responding high risk events has not been included due to a failure of the referral pathway for NFO caused by an IT upgrade within SAS with a new process trialled by SAS. This has delayed until November.	New SLAs developed Phase 2 for MAT 7 and MAT 9 commenced Developing better mechanisms for capturing numerical and experiential data Experiential Plan developed with Lived Experience Panel to include feedback to ADP subgroups delivering plan Mapping of MAT Standards across other commissioned service and to include Justice Services	6. Health Inequalities	**Green - On Track**	**Amber - At risk - requires action**
Rheumatology workforce model redesign		An options appraisal is underway for the workforce model that can deliver the service needs. Baseline work underway to understand the capacity of the resource and the demand for service - this involves review of overdue review patients, review of referrals process and review of internal processes		1. Primary and Community Care	**Green - On Track**	**Amber - At risk - requires action**
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	Guide has been circulated across clinical groups and will be considered in detail in the coming months, including delivery of targeted patient reviews	Circulation of guide to key stakeholders within the Board	10. Climate	**Green - On Track**	**Amber - At risk - requires action**
Targeted actions to improve the quality of our Immunisation services	1.2	Limited progress on proposals within 2023 Strategic Review of Childhood Immunisation Programme. Proposed new 'transformation oversight group' structure approved within 2024 - 2027 Immunisation Strategic Framework submitted to Public Health & Wellbeing Committee 01/07/24. This will bring together inclusion and quality improvement work and report into CIS programme board. Improvement activity groups for childhood, teenage & adult programmes to sit under this oversight group. Limited capacity from service nursing leads to engage over Autumn /Winter programme may delay progress. Paper brought to CIS programme Board on 01/10/24 outlining position.	QI work programme	1. Primary and Community Care	**Green - On Track**	**Amber - At risk - requires action**
Translation and implementation of agreed Business case Options for Co-badged Clinical Trials Unit/ Clinical Research Facility with University of St Andrews		St Andrews staff changes and appointment of new Dean in 4Q 24/25. Meetings with new Director of Research at St Andrews. Focus of discussions has become about Sponsorship, meeting planned with leadership from St Andrews in Oct/November		6. Health Inequalities	**Green - On Track**	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Improving effective governance and monitoring systems for IPC to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement		All milestones completed; awaiting further information on the implementation timeline of InPhase in NHS Scotland. ICM to join NHS Fife InPhase project team Lead IPCN contributed to the national task and finish group to establish requirements for a once for Scotland eSurveillance system for IPCTs	MEG- completion of initial scoping exercise and quote for IPC Audits across NHS Fife. InPhase - Introductory meeting with NHS Fife D&I and Clinical Governance teams Completion of first Task and Finish Group for once for Scotland eSurveillance system			**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.		The IPCT have launched the new IPC Link Practitioner Framework across NHS Fife in September 2024, after a successful pilot at QMH. IPCT welcome the opportunity to facilitate a hub and spoke model with 1 day placements for student nurse`s.  Furthermore, NHS Fife IPCT were invited to deliver bespoke IPC training to over 100 second year student nurse`s at University of Dundee School of Nursing Fife campus. NHS Fife IPCT are engaging with the consultation process for new LDP standards with ARHAI Scotland. Changes to the NIPCM and TBPs - postponed by ARHAI Scotland to Spring 2025.	Explore opportunities for implementing IPC Link Practitioner Framework Further develop student nurse placements with the IPCT Engagement with ARHAI Scotland for new LDP standards for CDI, ECB and SAB		**Amber - At risk - requires action**	**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	Work started on the refresh of the Cancer Framework. A comparison between the Cancer Strategy for Scotland and Population, Health and Wellbeing Strategy has been carried out to identify gaps. A refreshed Framework has been created in draft format. Meetings are in the process of being arranged to review commitments		5. Cancer Care	**Green - On Track**	**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 streams have commenced in inpatient areas, week commencing 9 Sep. Full Implementation will be rolled out Apr-25 with new annual leave allocation. Pause on antenatal audits as implementation of RSV. Antenatal Education, positive reviews from service users.	Continuity of carer: Implementation plan has an extended date of June 26. Recruitment has taken place and vacant posts appointed to. Full implementation is expected within the timeframe. Antenatal education programme is in place and being reviewed on a regular basis Neonatal redesign - continued engagement with Regional planning team to review modelling and escalate concerns.	7. Women & Children Health	**Green - On Track**	**Green - On Track**
CAMHS will achieve full compliance with CAMHS and Psychological Therapies National data set and enhance systems to achieve compliance.	3.3	This work continues in order that the service can achieve full compliance.	Work with system supplier to embed supplementary questionnaire within TrakCare as part of current clinical workflow to allow recording Work with NHS Fife Information Services to ensure reporting of items from supplementary questionnaire	3. Mental Health	**Green - On Track**	**Green - On Track**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Community Mental Health Teams for Adult and Older Adult services that are responsive to need and reduce admission by offering alternative pathways	3.2	Process maps finalised - management team will arrange sessions with the 3 localities to go through the new processes and will be embedded by end October 2024. New OA CMHT SOP near completion and will be ready to be shared at the policy and procedure group at the end of the year. New Transition of care between adult and older adult services SOP has been ratified at the policy and procedures group 18/09/2024 and will be circulated thereafter. 3 localities - East, West and Central are all now co-located - some remedial works have just been completed in Central.	Continue progression of CMHT development now encompassed within scope of the Reform, Transform and Perform Framework. 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 2024/5 Integration of SW/Third Sector as part of CMHTs	3. Mental Health	Green - On Track	Green - On Track
Comply with the requirements of the COVID enquiry and Operation Koper, Crown Office.		Ongoing requests for information, provided as requested for the different COVID-19 inquiries	Provide information as requested to aid the COVID-19 inquiries		Green - On Track	Green - On Track
Continued development of digital front door for patients	9.62	Waiting List Validation work completed. Digital Letters testing ongoing	Extension of Waiting List Validation	9. Digital & Innovation	Green - On Track	Green - On Track
Continue to ensure EiC is represented in all improvement and fundamentals of care delivery groups		Ongoing	Link practitioner event for falls in September, CAIR used to show data		Green - On Track	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.		Regional service in hours, and local service out of hours.		1. Primary and Community Care	Green - On Track	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 guidance and funding unchanged. Additional recruitment to East Region Health Protection Service completed, which will support early stages of investigation and response. Community testing functions would require to be stood-up again, and being explored as part of HCID pathways.	Have additional workforce in post to support any VAM response. Draw on findings of inquiries.	1. Primary and Community Care	Green - On Track	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	On trajectory. Orthopaedic waiting times reducing with no Fife patients over 102 weeks. Ophthalmology numbers remain high and focus on theatre efficiency to increase throughput. Cancer and diagnostics monitored through weekly meetings.	New OP waiting list at end Sept 31,783 against proposed figure of 33,532	4. Planned Care	Green - On Track	Green - On Track
Delivery of Care at Home / Commissioning: Maximise capacity, and commission and deliver care at home to meet locality needs	2.3	Team to commence reviews of packages first week in October	Review of packages to comment in next quarter regarding change of equipment provided. Reducing the unit cost on target also - increase in hours provided inhouse reducing the unit cost	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track
Delivery of Clinical Governance Strategic Framework		Overall on track to deliver; update scheduled for CGC in November 24	Delivery of work plan		Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Delivery of Clinical Governance Strategic Framework - Adverse Events		Adverse event lead is working collaboratively with 2 other boards as an expert advisor to devise and deliver 'Safety Learning Reviewer' foundation programme. The programme is the first step in Scotland's Health and Social Care, to provide education on human factors and a training package to assist boards to embed human factors approaches to adverse event reviews consistently.	Development of human factors approach to support Adverse Events management and proactive quality planning.		Green - On Track	Green - On Track
Delivery of the objectives set within the Pharmacy and Medicines Strategic Framework for 2024-2026		Strategic framework objectives have been agreed within Pharmacy and are progressing with agreed leadership	Deliverables within each workstream agreed and outline plans in place	8. Workforce	Green - On Track	Green - On Track
Delivery of the Risk Management Framework		Awaiting outcome of the work on risk appetite and on track for completion.			Green - On Track	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		Framework at final draft stage. Shared governance model agreed, to be launched and implemented.		8. Workforce	Green - On Track	Green - On Track
Develop, Enhance and re-invigorate Regional Networks	4.4	Regional working across a range of specialties continues. Progression made with bariatric services and reciprocal hernia surgery with NHS Lothian.	Aim to complete recruitment for long term vascular vacancy achieved.	4. Planned Care	Green - On Track	Green - On Track
Development and Implementation of an Adult Neurodevelopmental Pathway with clear links to CYP NDD Pathway.	3.1	Service recommendations presented to CCCS QMAQ and awaiting feedback.	Service recommendations to be presented via C&CCS QMAG initially for consideration. Cost neutral recommendations to be considered.	3. Mental Health	Green - On Track	Green - On Track
Development of Medical Education Strategic Framework		Through various methods local teams have been encouraged to consider current and future atlas of variations RM work now incorporated into the RTP Programme.	Review of draft framework with wider engagement to develop further		Green - On Track	Green - On Track
Enabling a "hospital within a hospital" approach in order to protect the delivery of planned care.	4.2	Continue to focus day surgery within QMH and scheduling of VHK day surgery kept to a minimum. No cancellations of lists within Q2 due to bed pressures		4. Planned Care	Green - On Track	Green - On Track
Engage with Higher Education Institutions locally and regionally to develop collaborative way of working	9.5	Regular meetings with Academic Liaison Group set up. Collaborative working opportunities can be identified via this group. Connections made with University of St Andrews funding specialists for potential collaborations.	Attend meetings of the HISES Academic Liaison Group of 5 regional Universities plus 3 regional NHS Boards.	9. Digital & Innovation	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Enhance Theatre efficiency	4.1	Theatre efficiency on average 85%. Continue to monitor activity through Theatre Action Group monthly and minimise elective cancellation on the day. Continue to explore opportunities to increase trauma operating capacity. Actively contacting patients to ensure DNA rates remain low. Backfill of unused sessions being utilised with waiting times monies to increase cost efficiency whilst managing waiting times.	All targets for Green Theatre Project have been met. Target of reducing spend by £100K by end Q2 delivered (actual £130K).	4. Planned Care	Green - On Track	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	Waiting Well workshop planned for October 2024 to promote existing work.	SLWG to convene to assess pathways and minimise duplication of work across Acute and Community.	4. Planned Care	Green - On Track	Green - On Track
Ensuring there is a sustainable Out of Hours service, utilising multi-disciplinary teams.	1.3	This work remains ongoing and on track to achieve milestones.	Trial additional MDT roles within UCSF, including Pharmacy and Mental Health roles	1. Primary and Community Care	Green - On Track	Green - On Track
Expanding Endoscopy capacity and workforce	5.2	Continue to have low waiting times compared to Scotland average. Surveillance numbers of cancer monitoring at lowest number for some time. Telephone pre-assessment has improved patient experience and reduced unnecessary cancellations	Test and implementation of telephone pre-assessment for endoscopy patients	5. Cancer Care	Green - On Track	Green - On Track
Extending the scope of day surgery and 23-hour surgery to increase activity and maximise single procedure lists.	4.5	Increasing utilisation of block room continues	Training of anaesthetists for block usage and development of SOP to support new pathways	4. Planned Care	Green - On Track	Green - On Track
Implement outcomes of Specialist Delivery Groups including reducing variation.	4.6	All areas performing and feedback on heat map to SG shows engagement across all specialties.		4. Planned Care	Green - On Track	Green - On Track
Improve compliance with CAPTND dataset	3.1	Fife Psychology Service continuing work on Trak implementation - IT advising will be implemented 16/12/24		3. Mental Health	Green - On Track	Green - On Track
Improve the mental health services build environment and improve patient safety	3.6	Programme of works established with revised dates for phase 1 (Ward 1 to Ward 3) completed	Revise programme of work to move Ward 1 first to Ward 3 followed by Ravenscraig to ward 1. Dates established for move due to delay in redesign and works completion: March 2025	3. Mental Health	Green - On Track	Green - On Track
Increase NHS Fife Innovation Test Bed activity		Terms of reference for Steering Group confirmed and monthly meetings confirmed. Monthly review by Steering Group to confirm governance routes, or identify efficiencies for the group.	Confirm Terms of Reference for Group. Review governance routes to identify any efficiencies and improvements	9. Digital & Innovation	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Increase redirection rate utilising flow and navigation (NHS 24 78%, GP 19%).	2.2	CBC calls continue to increase. FNC data submitted monthly to National team in line with data definitions.	Schedule of patients TOC High priority placed on alternative pathways and support given to ANPs with GP discussion	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track
Increase the number of SCN utilising the CAIR dashboard to inform improvements whilst creating a culture of learning and sharing between areas		EiC lead shares progress of CAIR users with HON across Acute and HSCP	Numbers reported to SG		Green - On Track	Green - On Track
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.		High uptake of SICPs training sessions across Fife Care Homes Care Home IPCT over 70% of care Homes have partaken in annual IPC Assurance walkarounds	Promote SICPs training sessions to all care homes in Fife Promotion of yearly IPC assurance walkabouts to all Homes	8. Workforce	Green - On Track	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		Continue to work with Clinical Governance to improve service and try to reduce amount of legal claims	Ongoing. Raise awareness of claims - similar claims and implement new procedures to avoid future claims		Green - On Track	Green - On Track
Local Enhanced Services Review		There is a risk that by carrying out this review, in light of wider sustainability pressures, practices stop some LES, impacting on HSCP service delivery. Working closely with practices, LMC and GP Sub-Group to conduct a full review, ensuring recommendations and action planning are fully scrutinised prior to implementation.		1. Primary and Community Care	Green - On Track	Green - On Track
Local - Implement Paperlite / Electronic Patient Record	9.61	Plan agreed by Steering Group	Complete Waiting List Validation work	9. Digital & Innovation	Green - On Track	Green - On Track
Maximising Scheduled Care capacity	4.3	Overall waiting times on track with the submitted trajectories presented to FP&R in July. Backfill and additional theatre lists throughout Q2 and increase on OP activity.		4. Planned Care	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
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	Coproduction work continuing, focused on identifying potential opportunities within existing funding.		3. Mental Health	Green - On Track	Green - On Track
Non-compliant Rotas		Assurance remains as moderate due to controls put in place at service level to encourage rota compliance. Rota monitoring began in September 2024. A second stage of monitoring will be completed from February 2025 with final savings being reported at the end of the financial year.	Approve SOPs/escalation process Approve and distribute new induction packs and implementation Approval of Wellbeing comms Potential Doctors mess redesign Rotas go live, monitoring to commence Communications strategy for new DDiT & Gateway EU live Rota monitoring begins		Green - On Track	Green - On Track
Ongoing development of Community Treatment and care (CTACT) services, supporting more local access to a wider range of services.	1.2	Initial hubs commence middle of October 2024, with initial focus on ear care clinics Continued development of HUBS to support MOU2 .		1. Primary and Community Care	Green - On Track	Green - On Track
Pandemic Preparedness: Critical to major incident levels.		NHS Fife Pandemic Framework document draft in progress	COVID -19 Public Enquiry module 1 recommendations to be published		Green - On Track	Green - On Track
Preventing alcohol specific and drug related harm and death affecting children and young people	6.2	On Track Rapid Action Group established more fully. All actions have commenced and are overseen by a senior leadership meeting on a monthly basis. Links to CPC supported. Continual monitoring of harm has continued. CPC training focused on risk in development and to be delivered next quarter. Changes to hospital liaison pathway agreed including use of third sector QR code and education provision changes to be rolled out	Actions within action plan to commence Regular monthly meetings of rapid action group to continue YP and children alcohol and drug use training plan for workforce to begin Thorough monitoring of data including hospitalisation rates, ED attendance and non fatal overdoses to continue	6. Health Inequalities	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Prevention & Early Intervention: new models of care ensuring early discharge and prevention of admission, and local frameworks for frailty	2.6	South West Fife Locality currently trained and on patient 5 out of 6 on Test of Change. Dunfermline also now have trained staff that can undertaken IV Abs. Additional staff across Fife are now also undertaking training. DN ANP's are now undertaking Frailty assessments and preventing hospital admissions and re-admissions. Discussions are being held as to how this work can be increased.		2. Urgent and Unscheduled Care	Green - On Track	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	Assessment practitioners based within hospital settings to facilitate discharge as soon as fit to leave Delayed discharges have remained at low level in 2 years DN ANP's are now undertaking Frailty assessments and preventing hospital admissions and re-admissions (FELS) - Increased capacity achieved. Drivers to technician Change management process advancing to completion.		2. Urgent and Unscheduled Care	Green - On Track	Green - On Track
Reprovision of unscheduled care/ crisis care provision for patients presenting out of hours with a mental health crisis	3.1	Undertake MHUUC Project Board directed activities to develop evidence base to support development of change and improvement ideas for MH urgent care	Progress delivery of Mental Health Urgent & Unscheduled Care (MHUUC) Project to benchmark and develop options appraisal for service improvement	3. Mental Health	Green - On Track	Green - On Track
Review of actions outlined in the Framework for Effective Cancer management to improve delivery of Cancer Waiting Times	5.3	Ongoing review of the Optimal Lung Cancer Pathway with improvements made and actions identified Review of the Prostate Improvement Group to revise purpose and remit.		5. Cancer Care	Green - On Track	Green - On Track
Scoping further areas to support Public Health/ NHS Fife priorities for evaluation and research.		Continue to scope and contribute to areas which would benefit from Public Health research/evaluation input including inequities in palliative care, evaluating impact of green health initiative and considering ways to demonstrate impact of inclusion health framework	Contribute to discussions around evaluating impact of different areas of work being taken forward across Fife to improve the health of the Fife population	6. Health Inequalities	Green - On Track	Green - On Track
Support for Doctoral Training Program (DTP) Fellows		Budget review submitted with some discussion re: duplication and accurate reporting from Finance Dept at University of St Andrews. Meetings with potential Cohort 4 candidates took place, 6 selected for interview	Budget reviews for Cohort 1 and Cohort 2 to submit to Wellcome Trust/DTP. Cohort 4 interviews and selection.	8. Workforce	Green - On Track	Green - On Track
To develop the resilience risk profiling for Emergency Planning for NHS Fife.		Emergency planning metrics are currently being assessed for EPRR report metrics with Datix administrators	Meeting with risk and governance Director July 24 to agree risk profiling metrics /reporting procedure for NHS Fife	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
To meet the recommendations of the WHP by end Dec 2024	7.2	Nurse led appointments have reduced menopause waiting times from 54 weeks to 15 weeks with increased nurse and consultant cover. Menopause educational activities in place in secondary care. Discussions ongoing with GPs re: new BMS on line training. Unable to expand EPC scanning with current clinical geography and band of EPC staff. Significant investment required to workforce. Currently good access to bereavement nurse for all pregnancy loss patients at all gestations All TOP patients get offered post TOP contraception. TOPS rates rising nationally.	Endometriosis is now covered within the existing gynaecology OP nurse team as noted in Q1 with a specific focus on signposting to existing services for pain management to prepare for surgical journey if this is the chosen pathway.	7. Women & Children Health	Green - On Track	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.		HCSA Quarter 1 Report submitted to Fife NHS Board meeting on 25 September 2024. Initial HIS Board Engagement meeting held 9/09/2025.	Continued 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	Green - On Track
Undertake regular waiting list validation.	4.7	Use of patient hub to contact patients to assess ongoing need for surgery.	Implementation of weekly validation report to medical secretaries.	4. Planned Care	Green - On Track	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	Work started on the refresh of the Cancer Framework. A comparison between the Cancer Strategy for Scotland and Population, Health and Wellbeing Strategy has been carried out to identify gaps. A refreshed Framework has been created in draft format. Meetings are in the process of being arranged to review commitments		5. Cancer Care	Green - On Track	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	Shared care remains in place, however unable to fund deliver Open Eyes locally, which has reduced our ability to fully deliver Glaucoma shared care scheme	Review and assess the role and impact of FICOS on supporting secondary and secondary care models	1. Primary and Community Care	Green - On Track	Green - On Track
Delivery of Research Innovation and Knowledge Strategy		Draft RIK Strategic priorities identified from Development Day Workshop session, reviewed and comments from RIK leadership team incorporated. Survey developed for input/comments from RIK Dept staff.	Draft RIK Strategic Priorities generated and available for review by RIK leadership team	9. Digital & Innovation		Green - On Track
Embed Quality of Care Review Guidance (QoC) within all adult inpatient and community areas		Launch of national guidance Sept 2024, EiC lead meeting with HON and lead nurses	Testing guidance			Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Embed the National Leading Excellence In Care Education and Development Framework into existing and new education programmes		Ongoing	Ongoing review			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	MDO protocol meeting held 29/8/24. Next review of MDO protocol due Aug 2025. Procedure for ensuring follow up on release from prison remains in date and appropriate (next review due Aug 2026)	Training sessions on MDO protocol delivered on 27/3/24, 8/4/24, 29/3/24, 2/5/24. Multiagency MDO protocol review meeting has been arranged for 29/8/24.	3. Mental Health	Green - On Track	Blue - Complete/ Target met
Implement national Excellence in Care (EIC) objectives within NHS Fife In line with 3 Year strategy, embed in Fife by 2025.		New objectives written	New objectives written		Green - On Track	Blue - Complete/ Target met
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					Blue - Complete/ Target met	Blue - Complete/ Target met
Ensure the delivery of an effective resilience function for NHS Fife.		EPRR Framework documents are now published. Emergency planning and exercising ongoing. Business Continuity support to services ongoing.		6. Health Inequalities	Blue - Complete/ Target met	Blue - Complete/ Target met

To Improve Staff Experience and Wellbeing

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Carers will have access to information where and when they want, that helps them to manage their caring role.	6.1	The investment for additional staff to lead on the production and delivery of awareness raising campaigns has been cut from 3 staff to just 1, with the expectation that this will increase back to 3 staff next financial year. The recruitment of a Project Worker to lead on this work was not successful in recruiting a suitable candidate. The role will be readvertised in Q3. As a result the action is behind schedule.	Plan and begin delivery of improvements resulting from Carers Experience Survey.	6. Health Inequalities	Amber - At risk - requires action	Amber - At risk - requires action
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	Analysis on an ongoing basis of the existing staffing model to ensure HV pathway is being delivered.		7. Women & Children Health	Amber - At risk - requires action	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	a review of the eligibility criteria is being led by the Principal Social Work Officer. This work is in the early stages to which we have contributed information about eligibility regarding unpaid carers and other authorities approach to eligibility criteria for unpaid carers' access to additional support.	We will review the local eligibility criteria to ensure it meets best and common practice with a view to increasing opportunities for earlier intervention that is also fully aligned to national carers strategy and national care service	6. Health Inequalities	Amber - At risk - requires action	Amber - At risk - requires action
National - eRostering	9.1	Rosters to be rebuilt to support RWW and Finance Establishment corrections		9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action
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	A planned review of the Social Work Assistants (Carers) has started but not completed yet. The results of the satisfaction survey are being worked on and further work will take place during Q3 to progress the review of the model.		6. Health Inequalities	Green - On Track	Amber - At risk - requires action
PPD Succession Planning		In collaboration with Services, ~180 NQP recruited to B5 vacancies. Cohort 3 Assistant Practitioner now complete. 3 Return to Practice staff now in post (1 x Acute, 2 x Partnership). 5 HCSW recruited to the Open University programme (4 x Adult, 1 x Mental Health). 11 HCSW recruited to hence programme (9 x Adult, 2 x Mental Health, 1 x Learning Disability).	Review current training programme and commence regular meetings with Fife College and partner HEIs.		Amber - At risk - requires action	Green - On Track
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		Most recent cohort have been retained into operational roles per plans - this ensures development of the skill mix within Pharmacy	Planning for recruitment and exploring options to create local pipeline via Modern Apprenticeships Retention of current cohort into operational roles		Amber - At risk - requires action	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Continue to deliver and enlarge on Staff Support/VBRP Project.		Ongoing collaborative work with a number of aligned services to support delivery of this project	In order to evaluate the programme, IPQR measures (e.g. Scottish Spiritual Care Patient Reported Outcome Measure) in place for Spiritual Care along with staff feedback will be used to: Establish how, through the provision of dedicated resources, the continued delivery of project has supported the development and delivery of VBRP® within NHS Fife; Evaluate the value of VBRP® to staff well being, Demonstrate how learning from and development of VBRP® was shared across the organisation, Explore how reflective practice is essential if we are to learn from what happened to develop and improve not only our future practice, but our personal and professional wellbeing too, reconnecting with the values that brought us into healthcare; Evaluation of how the implementation of offering a dedicated reflective space supports recovery and supports resilience amongst staff and; Communicate with all staff ensuring those staff groups which have not previously engaged in Phase 1 are targeted. This includes offering VBRP® on a variety of sites and days / times. Identify any barriers which may prevent certain staff teams / groups engage with VBRP® and work with Heads of Departments and service managers to overcome such barriers	8. Workforce	Green - On Track	Green - On Track
Delivering Anchor Institution workforce aims - Promoting employability priorities	6.4	EMERGE programme commenced August 2024 in collaboration with Fife College. Life Chances programme launched in September 2024.	Implementation of Employability Action Plan in line with Anchor ambitions, ADP and Workforce Planning priorities.	6. Health Inequalities	Green - On Track	Green - On Track
Delivery of Staff Health & Wellbeing Framework aims for 2023 to 2025	8.3	Identification of an accreditation framework underway.	Consideration of impact of outputs of activities on absence and other agreed measures and review.	8. Workforce	Green - On Track	Green - On Track
Delivery of the eRostering (eR) Implementation Programme in conjunction with Digital & Information.		Rollout of SafeCare within 7 HSCP wards. Review of Acute activity necessitates rebuild of some rosters and re-alignment to finances. Pause in Acute activity until corrections completed.	BAU Team established and in place.	8. Workforce	Green - On Track	Green - On Track
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	Work continues to be taken forward to both increase staffing across CIS and CTAC as an integrated Service and advances around Locality based teams	Workforce education strategy & training programme.	1. Primary and Community Care	Green - On Track	Green - On Track
Development and implementation of the NHS Fife Workforce Plan for 2022-2025	8.5	Exploring linkage between RTP and future shape / size of workforce, exploring some analytics with D&I. Revised SG Workforce Planning guidance with timescales for publication of 2025-2028 Workforce Plan publication anticipated to be issued within near future.	Review and continued development of Service level Workforce Plans.	8. Workforce	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
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.		On track. Board continues to increase DPP numbers as a key enabler of future prescribers	PGFTPs commence on revised rotational programme Further Legacy staff commence IP course. First cohort of PSWs complete MA. Revised rotational programme for B6 and B7 Pharmacists agreed DPPs increased to 11 Increase peer review for staff on programmes.	8. Workforce	Green - On Track	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		FTY pharmacists started with cohorts also completing in November. Development of internal approaches following review is ongoing. Simulation planning also ongoing. .	Foundation year trainee pharmacists start. Further completion of cohorts at end November. This new cohort will have a revised approach to prescribing education, developing towards graduate prescribers from 2025/26, around a six week block in one clinical area Board considering role of simulation in Fife		Green - On Track	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	The work remains ongoing in partnership with our commissioned third sector partners. The additional internal role for participation and engagement has been vacated. This, together with the unsuccessful recruitment noted in reference HBE2425-01, may have an impact on the delivery of this specific action which itself is secondary to the other support offered in schools to support unpaid young carers.		6. Health Inequalities	Green - On Track	Green - On Track
Improving support and developing the Mental Health workforce	3.5	Service redesign proposals in order to achieve financial efficiencies have been submitted for approval to SLT. Workforce tools due to be run for inpatient services in October however application of outcomes will need to reflect outcome of proposals	Establish Workforce projections and skill mix required, informed by workforce tools. Develop workforce plan, aligned to national MH workforce delivery plan and local strategy	3. Mental Health	Green - On Track	Green - On Track
Medical Workforce Recruitment and Retention Strategic Framework		Medical Workforce review underway in the Acute Division to provide baseline data			Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Progression with ScotCOM in collaboration with the University of St Andrews		Student numbers reached to go live with programme as planned. Work continues to secure full GMC approval. Recruitment for clinical educators and support staff started.	Staff recruitment to support ScotCOM programme. Collaborative working with NHS Forth Valley and Borders.		Green - On Track	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	the review of the Short Breaks Service Statement has commenced. Additional investment in short breaks has been commissioned although only a third of the available investments has been commissioned due to our partners' risk assessment of deliverability with the resources available and significant sector wide recruitment challenges. We aim to secure further commitments as staff members are recruited. This is a systemic and longer term sector wide issue.	Commence a complete a review and update our short breaks service statement (SBSS).	6. Health Inequalities	Green - On Track	Green - On Track
We will launch and develop a leadership framework – Our Leadership Way in Fife.		The volunteer group have met twice (July & Sept) and have begun to build further insights into the core leadership behaviours that matter the most. Plans are emerging to set up focus groups in Nov-Jan, and to extend efforts to reach the broad network of the volunteer group.	The collaborative volunteer group will look to build on the SLG initial exploration of Our Leadership Way by; Exploring ways to gather further perspectives on the leadership behaviours that matter, matter the most; develop and take forward the initial ideas for action to form a programme of work that will underpin the leadership framework.	8. Workforce	Green - On Track	Green - On Track

To Deliver Value & Sustainability

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Business Transformation		Bridging actions identified Mid Year review being completed	PID Approved Agreement of workforce mechanisms to support transformation Further development of digital solutions planning Establishment of programme to support project delivery (co-ordination of digital enablers and delivery of direct impact projects, including work on a new model for 'administration services'	9. Digital & Innovation	Red - Unlikely to complete on time/meet target	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.		Preparatory work continues, however funding has not yet been secured to progress the full ambition around automation. Discussions are ongoing	Progress on centralisation of procurement to VHK, including establishment of workplan and agreed dates		Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
SLA and External Activity		Whilst there is ongoing review of the data to establish opportunities, there is national discussion on SLA potential uplifts through FLG, CFN and DOFs. There is likely to be a separate DOF session to further discuss with a view to achieving resolution.	Ongoing review of data to help establish opportunities for repatriation and identify reasons for inappropriate referrals to other boards Ongoing development of Performance Management group and subsequent arrangements with NHS Lothian and NHS Tayside		Red - Unlikely to complete on time/meet target	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	Supported Discharge Units implemented in July however due to continued increased demand occupancy has remained at over 100% of agreed 30 beds. Locum surge Consultant remains after a review with Clinical leads. Gateway Dr's & JCF's supporting 6&9 and surge model.	Reduction of Ward 9 to 11 beds and associated maintenance of new footprint Launch of Supported Discharge Units Awareness Raising Programme of Discharge Planning & Surge Review of Locum Surge Consultant post	2. Urgent and Unscheduled Care	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Roll out of Digital Pathology	5.1	No progress due to difficulties with LIMS, Vantage and Digital Pathology integration, meetings are being held to find resolution.		5. Cancer Care	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target
Implement Same Day Emergency Care (SDEC) and rapid assessment pathways	2.2	Development of final re-design elements prior to re submission of final plan prior to implementation. Flow improved across Front Door with Ambulance Turnaround Times achieving trajectory.	Redesign TOC SDEC commenced	2. Urgent and Unscheduled Care	Green - On Track	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	Local implementation (phase one) continues with significant numbers of issues still to be resolved. National timeline remains unclear.		9. Digital & Innovation	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation	8.1	We continue to onboard staffing groups beyond nursing as we move to a staff bank however we do not have the financial envelope to consolidate all local banks as this time. There fore there is a risk this is not delivered by March 2027.	Continue implementation of Direct Engagement under RTP and then transition of medical locums into Staff Bank	8. Workforce	**Amber - At risk - requires action**	**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		Significant focus both in Pharmacy, Digital and wider MDT on delivery of stock control system and meds rec system, from September through to Spring 2025 particularly. Timelines are challenging but plans for delivery are in place.	UAT on meds rec system following change controls Further build and train of pharmacy stock control - primary file control complete Preliminary start of HEPMA build. Project plan finalised.	9. Digital & Innovation	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Enhanced data availability and sharing		Work continues with Finance and Workforce on data availability - items being built	Work commence with availability of corporate data	9. Digital & Innovation	**Amber - At risk - requires action**	**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	Work is on going to review the combined monitor (NHS & FC) spend on Mental Health. Once confirmed, this will allow us to gain greater understanding of the totality of spend against frontline services and the ability to deliver by March 2026 (noting the SG target - 10% of the boards income is given to MH services). Q3 and Q4 milestones may need to be reviewed in due course.		3. Mental Health	**Amber - At risk - requires action**	**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	MIU re-directions improved to 80%. Breaches have reduced by 50% compared to same time previous year	Review of overnight provision ensuring patients go attend right place New skill-mix staffing model to support minors triage and reduce waits implemented	2. Urgent and Unscheduled Care	**Amber - At risk - requires action**	**Amber - At risk - requires action**
National - GP IT Reprovisioning - GP Sustainability	9.1	Business Case moves through Primary Care Governance Delays to Docman Upgrade	Have agreed implementation plan	9. Digital & Innovation	**Amber - At risk - requires action**	**Amber - At risk - requires action**
National - LIMS Implementation	9.1	Await delivery via National Teams		9. Digital & Innovation	**Amber - At risk - requires action**	**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.		We will continue to develop the programme of works. SG have confirmed the LCITP funding route is closed. Previously stated milestones relating to this funding will not be completed.	Full development of programme of works showing alignment to 2030 emissions targets	10. Climate	**Amber - At risk - requires action**	**Amber - At risk - requires action**
Digital & Information Projects	9.31	Ongoing	Assess Benefits for Quarter	9. Digital & Innovation	**Green - On Track**	**Amber - At risk - requires action**

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets		The Board is ahead of previous years in delivery of medicines efficiencies work. However, the scale of targets this year is high and there are challenges in securing full delivery. Significant engagement work across sectors and MDT is ongoing. The medicines waste campaign has been launched	Formal launch of medicines waste campaign for the public and staff, to reduce medicines waste and volume of prescribing. Ongoing delivery of Medicines efficiencies plans across Acute services and HSCP, aligned to 15 box grid.	6. Health Inequalities	Green - On Track	Amber - At risk - requires action
To achieve additional capacity to meet 6 week target for access to 3 key Radiology diagnostic tests (MR,CT and US)	5.2	SG Funding to support additional CT MR and US activity has resulted in significant improvement of waiting times with 65% of patients being seen within the 6 week target in Aug-24, up from 45% in Mar-24. Withdrawal of US funding from end of quarter 2 will, without locum activity, reduce department's capacity. Monthly demand exceeds core capacity by 132 patients (2,168 - 2,036). By 31 Mar-25 longest waiting time will likely exceed 15 weeks.	Ongoing monitoring of DCAQ, processes in place to monitor cancellations ,short notice cancellation processes in place to maximise capacity, booking guidance SOP's updated and staff training programme development. Collaborative work with service leads to monitor diagnostic turnaround times and assess options for optimising pathways Review of Radiology out of hours service to maximise efficiency to support hospital flow particularly in light of new models of care in medical and surgical directorates. Radiology OOH service currently adopts an on-call model, this requires financial investment to expand to a shift system with increased workforce to meet the out of hours demand for imaging.	5. Cancer Care	Green - On Track	Amber - At risk - requires action
Develop and Implement the Corporate Communication Strategy		The Corporate Communications Strategy was approved by EDG in August 2024. The Communications team will now work to implement this inline with NHS Fife's Population Health and Wellbeing Strategy and Re-form, Transform and Perform objectives over the coming months and years. Supported by project communications plan and quarterly communications activity reports and evaluation.	Corporate Communications Strategy and Framework at EDG for approval on 1 Aug-24		Amber - At risk - requires action	Green - On Track
Develop and Implement the Public Participation and Community Engagement Strategy		The Public Participation and Community Engagement Strategy and Operational Plan were approved by the Board in July 2024. Now working to implement in support of projects associated with Re-form, Transform and Perform and coordinate activity with the HSCP Engagement Team as appropriate.	Community Engagement and Public Participation Strategy and Operational plan presented to Board on 30 Jul-24 Public Engagement Campaign launched in Sep-24 to help educate and inform the people of Fife of the pressures on the health care budget, changes that will need to be made to ensure and break-even position and opportunities around how they can help inform some of the more difficult decisions or changes to services being explored		Amber - At risk - requires action	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Develop Strategic vision across all of Primary Care	1.2	Progress to BAU status ongoing; current SLA with being explored for best value, with possible move to formal tender by end of financial year. Phase 3 PCIP Comms Plan commenced and progressing. CTAC and CIS continue to grow connections between the services; evaluation and final implementation plans progressing. PCIP update report presented across governing bodies July-Sept.	Progress Community Link Workers workstream to a state of business as usual. Commence phase three of the PCIP Communication Plan (public facing phase). Evaluate the effectiveness of the integration between CTAC and the Community Immunisation Service.	1. Primary and Community Care	Amber - At risk - requires action	Green - On Track
Procurement Savings within Acute Services		21 schemes in progress, In year on track for 79%/ FYE will be 88% of target: -2 cost avoidance (not included in target savings) -9 underway -4 due to commence Sept. -2 awaiting approval -4 having logistics worked up 11 other schemes in initial development. The aim is that these 11 will close the gap in the current in year impact forecast. Continued risk that objective will not be reached but continued activity to identify opportunities to mitigate this risk. Assurance is moderate.	Ongoing reviews of expenditure and savings opportunities.		Amber - At risk - requires action	Green - On Track
Support delivery of Re-form, Transform, Perform (RTP) through supporting service change		Standard RTP reporting established with reporting calendar. Portfolio approach agreed and further work will be delivered in Q3 Programmes now established with PIDs approved by NHS Fife Board. Programme Boards now meeting fortnightly.	Monthly performance reporting established Portfolio approach agreed 4 key Programmes established with Boards		Amber - At risk - requires action	Green - On Track
Achievement of Waste Targets as set out in DL(2021) 38	10.3	Waste initiatives progressed so far: Exploring funding for new bins and a trial within a ward is going ahead, a blueprint will then be created for all other wards with improved recycling processes. Glass recycling is in place. Updated posters and bin labelling has been applied.		10. Climate	Green - On Track	Green - On Track
Action plan for the National Green Theatres Programme		We are on target with the CfSD bundles. The most recent bundle included rub not scrub which NHS Fife has already adopted.	Continue to make progress with implementation bundles supplied by CfSD	10. Climate	Green - On Track	Green - On Track
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Recruitment Shared Services Implementation Consolidation & enhanced International Recruitment service		International recruitment saw 105 applicants join NHS Fife however due to finances this activity is paused for 24/25. Work continue on the ERRS model to introduce further phases of the model.	Continue to review of ERRS model to gain wider service benefits across the model	8. Workforce	Green - On Track	Green - On Track
Complete NHS Fife's Phase 2 M365 Programme		MCAS deployed	Complete implementation of additional security controls	9. Digital & Innovation	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Decarbonisation of Fleet in line with Targets	10.41	Infrastructure Update NHS Fife secured funding via Transport Scotland of £386,115.30. This supported infrastructure installs across 7 sites within NHS Fife. We also introduced an EV charging Hub at VHK site (located at the laundry area) This will facilitate charging of our 3.5t Luton vehicles for our 2030 decarbonisation objective.	Set out plans to increase charging infrastructure using 'switched on fleet' grant	10. Climate	Green - On Track	Green - On Track
Delivery of ICO and NISD Audit Improvement Plans Architecture and Resilience Developments	9.2	NISD Audit complete August 2024	Cyber Resilience Audit	9. Digital & Innovation	Green - On Track	Green - On Track
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	On Track - Evaluation complete and outcomes for staff and students are good. Workforce development commenced and school nurses have been trained in ABI and DBI to improve delivery and response to children and young people affected by alcohol and drug use.	Evaluate process and outcomes comparable to previous year and/or to other schools on staff confidence/knowledge and student knowledge Establish workforce development network alliance for school nursing, and third sector services delivering education, support and counselling to children and young people of school age	6. Health Inequalities	Green - On Track	Green - On Track
Delivery of Property and Asset Management Strategy		PAMS Strategy has been suspended by SG in favour of the Whole System Infrastructure Plan	Papers taken to FCIG, FP&R and the Board outlining the process for submission of part 1 to SG in January 2025	10. Climate	Green - On Track	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	The strategy was positively received and supported at IJB on the 27th of September.	Draft Strategy will be presented to NHS Fife Board and IJB for approval via committees Commence 1st phase of 3 year delivery plan	1. Primary and Community Care	Green - On Track	Green - On Track
Development and initiation of NHS Fife Innovation Project Review Group (IPRG)	9.5	NHS Fife Innovation Project Review Group Terms of Reference confirmed and meetings being set for every second month.	Confirm Terms of Reference for Group. Review governance routes to identify any efficiencies and improvements	9. Digital & Innovation	Green - On Track	Green - On Track
Development of a delivery plan to embed and deliver the Realistic Medicine Programme in NHS Fife		Through various methods local teams have been encouraged to consider current and future atlas of variations RM work now incorporated into the RTP Programme.	To encourage local teams consider current and future atlas of variations		Green - On Track	Green - On Track
Develop plans to make sure CIS delivers on key operational priorities	1.2	Clear governance process, with all scheduling plans overseen via the CIS Programme Board. This sees a review of individual plans and overarching, in terms of workforce, logistics and communication. Midwifery supporting flu and covid vaccinations		1. Primary and Community Care	Green - On Track	Green - On Track
Digital Enablement Workplan for patients and staff ITIL 4 Improvement	9.4	Ongoing	Key Process Review Implemented	9. Digital & Innovation	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Enhance the capacity and capability across the team		All procurement vacancies successfully filled. There is an ongoing development plan in place to improve knowledge and capability.			Green - On Track	Green - On Track
Estates Rationalisation		Work has progressed with the closure of HH and Cameron House and Haig House. Staff have moved into Fife Council (Fife House and Bankhead) Cameron phased decants are underway as planned and on track. Site plans for Stratheden and discussions with Fife Council are underway and on track	VHK E&F/L8 bookable desks works Identify further hot desk hubs Cameron alternative clinical area identified for displaced team Fife Council solutions in place (Fife House & Bankhead) including IT Cameron phased decants Site consolidation/disposal plans further developed		Green - On Track	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.		Focus on RTP led workforce growth analysis and refining HCSA reporting to satisfy future SG requirements and High Cost Agency legislative reporting. These align to eRostering, SafeCare and Workforce Planning actions.	Creation of on line Workforce information overview accessible within NHS Fife Review of Workforce Analytics as part of Directorate service change proposals completed Ongoing production and analysis of workforce information to support workforce planning and service delivery, including HCSA reporting requirements.	8. Workforce	Green - On Track	Green - On Track
Further strengthen our business partnering model, supported by a strong management accounting team, to improve business performance and decision making support.		Staffing turnover within the Financial Management Team has been a challenge, and it has been difficult to recruit to posts at all AFC bandings. At the commencement of Q2 we had 26% vacancies however at the end of Q2 we have identified 4 preferred candidates to 4 posts. The remaining 3 vacancies will be addressed as a priority but within vacancy panel conditions.			Green - On Track	Green - On Track
Implementation of environmental prescribing improvements per the Scottish Government Quality Prescribing for Respiratory guide 2024		We are undertaking targeted reviews of the use of dry powder inhalers in place of those containing propellants such as CFC, particularly for reliever inhalers, currently prescribed as metered dose inhalers (MDI). We are also exploring the potential reduction in the number of reliever MDI inhalers prescribed which are often disposed of unused/ partially used.		10. Climate	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Improve sustainability of Primary Care	1.1	Test an urgent Care hub within a cluster area (targeting cluster(s) with high referral rates into unscheduled Care) (On track to test in West of Fife) Test Urgent Care Hub close to Acute site to determine potential increased redirection rate (Consider this test post west of Fife test) Develop hub to establish MDT approach, across Primary care and community services (Consider this test post outcome of West of Fife Test) Develop workforce across in/out of hours (Consider SANP role in hours. Out of Hours testing Pharmacist resource in PHs and with quantify effectiveness of the role post October PH) 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. (In collaboration with UCSF) (As above west of Fife TOC)	Test an urgent Care hub within a cluster area (targeting cluster(s) with high referral rates into unscheduled Care) Test Urgent Care Hub close to Acute site to determine potential increased redirection rate Develop hub to establish MDT approach, across Primary care and community services Develop workforce across in/out of hours 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. (In collaboration with UCSF)	1. Primary and Community Care	Green - On Track	Green - On Track
Increase capability within the team to deliver service improvement and meet growing service demand		Development of the financial services team is ongoing. As of August 2024 the Direct Engagement process has gone live and the financial process has been robustly implemented.			Green - On Track	Green - On Track
Infrastructure - Workforce	9.31	Completed work for Cameron	Decommission Cameron Establish other hotdesking locations	9. Digital & Innovation	Green - On Track	Green - On Track
IPQR Review		Monthly reports continue to be produced and distributed to relevant groups. Population Health metrics relating to Screening and Child Health/ Development have now been incorporated. Quarterly review of trajectories complete, will be ongoing. Service updates are now collated on MSTeams, no issues reported. Team are currently exploring use of PowerBI, undertaking a 4-week course run by KIND network.	Embed new process for Service Updates Quarterly review of trajectories/targets Monthly reports produced and distributed accordingly Incorporate agreed metrics relating to Population Health Agree BI tool to use		Green - On Track	Green - On Track
Local - Records Management Plan Implementation	9.2	Ongoing		9. Digital & Innovation	Green - On Track	Green - On Track
Mental Health Services will have a robust data gathering and analysis system to allow for service planning and development	3.3	Mental health data group established as business as usual. Dashboard available and demand and capacity information in development	Dashboard with core dataset available to access Demand and Capacity data available for all specialities All Mental Health Quality Indicators will all be reported on monthly basis	3. Mental Health	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Outline plans to implement an approved Environmental Management System.		We have finalised our environmental policy and it has been approved by the board. It is not publicly available on our website	Have a full environmental policy approved by the board	10. Climate	Green - On Track	Green - On Track
Outline plans to implement a sustainable travel approach for business, commuter, patient and visitor travel		We have launched a year round cycle to work scheme with Halfords which is already had high staff uptake	Put in place a new cycle to work scheme for staff	10. Climate	Green - On Track	Green - On Track
Outline plans to increase biodiversity and improve greenspace across our estate		We hosted an online event alongside FCCAN which outlined greenspace opportunities to community groups. The event was successful and we have had many follow up discussions with community groups since.	Host a greenspace event to outline opportunities available to community groups	10. Climate	Green - On Track	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.		Two NHS Fife vacancies successfully filled. Dialogue continues with the consortium re further development. NHS Fife are a proactive member of the consortium board.			Green - On Track	Green - On Track
Reduction of Medical Gas Emissions through implementation of national guidance		Work is still ongoing and we are tracking usage. We are projecting the lowest use of nitrous this year since reporting began and we are tracking usage. We are introducing an alternative to Entonox in ED.	Review the use of cylinder use for Nitrous oxide and aim to reduce where possible	10. Climate	Green - On Track	Green - On Track
Refreshed Performance Reporting	6.1	These will be signed off on 4th October at the HSCP Performance Board	Finalise and agree KPI Metrics	6. Health Inequalities	Green - On Track	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	Collaborative work with the resilience team and forum has been ongoing. A connection with SEPA was recently made to address the flooding at Cameron Hospital		10. Climate	Green - On Track	Green - On Track
Support Delivery Strategic Planning function		ADP Q1 report was produced. Report was approved and tabled at EDG, Committees and Board. Submitted to SG, awaiting feedback. Adaptations were made to template to link to Corporate Objectives and relevant Strategies (where progress is reported through the PHWS progress report). Planning/Review process for System Flow was approved by Operational Group. Event held in August on MSTeams with attendees across the NHS and HSCP, write up is in progress.	Finalise Corporate Objectives for 24/25 and first CO review meeting Agree Planning/Review process for 24/25 Organise Planning/Review Event (Aug-24) ADP24/25 Q1 to be produced Ensure relevant NHS/HSCP Strategy updates are included within ADP24/25 to include in PHWS mid-year report		Green - On Track	Green - On Track
Transfer our referral system and EPR from Tiara to Morse and TrakCare within the Podiatry service		Transfer to trakcare is pending but we began planning with Digital around this .	Transfer successfully to Morse	1. Primary and Community Care	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Transformation of HR transactional activity enhancing the HR Operational delivery model through case management and manager support building on manager/ employee self-service		Work continues to identify funding for new posts, systems development and a transformation of the Workforce Directorate as a whole.	Appoint new Team Leaders, develop SOP's and service now.	8. Workforce	Green - On Track	Green - On Track
Delivery of Digital and Information Framework		Agreement to process via D&I Board		9. Digital & Innovation		Green - On Track
Refresh of the Primary Care Improvement Plan	1.1	In line National PCIP version 6; carry out extensive engagement with General Practice to delivery PCIP in line with specific needs of each Practice and cluster.		1. Primary and Community Care	Blue - Complete/ Target met	Blue - Complete/ Target met
Review existing arrangements which support children with neurodevelopmental differences.				7. Women & Children Health	Blue - Complete/ Target met	Blue - Complete/ Target met

ALL

Deliverable	ADP Reference	2024/25 Q2 Comment	2024/25 Q2 Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status
Develop the NHS Fife Organisational Change Model to support delivery of change.		Change model engagement work completed and begun drafting framework.	Complete engagement work and begin drafting framework.		Green - On Track	Green - On Track
Supporting implementation of the Population Health & Wellbeing Strategy		Work to develop framework for monitoring the Population Health and Wellbeing Strategy has been completed and write up of the Mid-Year Report has commenced. This will be presented to Board in Q3.	Finalise delivery framework for 2024-25 for the strategy		Green - On Track	Green - On Track

NHS Fife

Meeting: Clinical Governance Committee

Meeting date: 1 November 2024

Title: Clinical Governance Strategic Framework Delivery Plan 2024/25

Responsible Executive: Dr Chris McKenna, Medical Director

Report Author: Gemma Couser, Associate Director for Quality and Clinical Governance

Executive Summary

- Annually a delivery plan is developed to support attainment of the ambitions within the NHS Fife's Clinical Governance Strategic Framework
- Work will shortly commence to refresh the Clinical Governance Strategic Framework and associated delivery plan
- The delivery plan for 24/25 consists of the workstreams below:

		Workstreams
1. Our values	1.1	Organisational Learning
	1.2	Safety and Just Culture
2. Clinical Governance Activities	2.1	Deteriorating Patient Improvement Programme
	2.2	Adverse Events Policy and Procedure
	2.3	A Focus on Human Factors
	2.4	Duty of Candour Process Review
	2.5	Policies and Procedures
	2.6	Medicines Safety Programmes
3. Enablers	3.1	Datix Replacement
	3.2	National Early Warning Score 2 (NEWS2)
	3.3	Planning for Clinical Governance Strategic Framework Fresh

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio

- NHS Board / IJB Strategy or Direction / Plan for Fife
- NHS Fife Board Strategic Priorities
    - To Improve Health & Wellbeing
    - To improve Staff Experience and 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 and associated appendices provides an overview of the:

- Clinical Governance Strategic Framework Delivery Plan 2024/25

2.2 Background

The Clinical Governance Strategic Framework is fundamental to set out our aim of delivering safe, effective, patient-centred care as an organisation which listens, learns and improves. The Framework was designed to ensure alignment with our 4 strategic priorities. Each year we develop a workplan to sit alongside the Framework.

2.3 Assessment

Annual Delivery Plan

Appendix 1 sets out the Annual Delivery Plan for 2024/2025. The Clinical Governance Oversight Group provides oversight of this delivery plan. The delivery plan will be refreshed for 2025/26.

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	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.		

2.3.1 Quality, Patient and Value-Based Health & Care

Achieving safe, effective, patient centred care in an organisation which listens, learns and improves is the aim of the framework.

2.3.2 Workforce

The wellbeing and contribution of workforce is a key to this framework

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

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

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Clinical Governance Strategic Framework workplan has been developed through:

- Discussion with Executive Leads
- Feedback from key stakeholders

2.3.8 Route to the Meeting

Clinical Governance Oversight Group

2.4 Recommendation

- Members are asked to take a **"moderate"** level of **assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Clinical Governance Strategic Framework Delivery Plan 2024/25

Report Contact
Gemma Couser
Associate Director for Quality and Clinical Governance
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Clinical Governance Strategic Framework Annual Delivery Plan 2024/2025

- The principles and intentions set out in the Clinical Governance Strategic Framework will only be fully realised through the support of an annual delivery plan.
- Assurance and oversight of the delivery plan will be provided through the Clinical Governance Oversight Group supported by a midyear and end of year report to the Clinical Governance Committee. Any matters that require escalation will be escalated to these groups as appropriate.
- The annual delivery plan for 2024/2025 is set out below:

		Workstream	Description/ Objectives	Lead(s)	Timescale	Update/Status
Our Values: Care and Compassion Dignity and Respect Quality and Teamwork Openness, Honesty and Responsibility	1.1	Organisational Learning	Establish an approach for the complex and adaptive challenge of organisational learning including sharing of learning and quality improvement activities	Associate Director for Quality and Clinical Governance (Q&CG) and Director of Nursing (Corporate) and Deputy Medical Director	Mar 25 and ongoing	Current areas of focus: Development of a Learning from Clinical Experience Collaborative Increased focus on outcome 4 SAERs Creating connections between complaints, adverse events and claims
	1.2	Safety and Just Culture	Develop a programme of work to ensure that staff are supported to engage in a safe, open and transparent way with clinical governance activities	Lead for Adverse Events	Jun 24	Staff support following an Adverse Event pathway was supported by the Clinical Governance Oversight Group in August 24. Work underway to engage with divisional management teams to progress roll out.
Clinical Governance Activities	2.1	Deteriorating Patient Improvement Programme	Programme of work to reduce cardiac arrests by improved identification, communication and escalation of deteriorating patients in line with SIGN 167. : • Education and Training	Deteriorating Patient Clinical Lead, Associate Director of Q&CG and Clinical Effectiveness Manager – with leadership from across operational division and	Mar 25 and ongoing	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,

			• Digital and Information Systems to improve patient care • Supporting improvements in practice	Resuscitation lead		compliance with the structured response, completion of hospital anticipatory care plans and do not attempt cardiopulmonary resuscitation documents. Revised improvement plan to be confirmed October 24.
	2.2	Adverse Events Policy and Procedure	Review of the Adverse Events Trigger List and associated level of incident review	Lead for Adverse Events	Jan 25	Proposed changes to be implemented from 6th January 25. Paper seeking endorsement scheduled for Clinical Governance Oversight Group in October 24
	2.3	A focus on human factors	Implementation of a human factors approach to incident investigation	Lead for Adverse Events	Mar 25	NHS Education for Scotland (NES) pilot Safety learning review training due to start Nov 2024. Four nominees being identified from NHS Fife to contribute to delivery of cascade training.
	2.4	Duty of Candour Process Review	Review of Duty of Candour process to ensure consistency in application and appropriate alignment to Adverse Event process	Associate Director for Q&CG and Lead for Adverse Events	Mar 25	Draft process presented to CGOG in 2023 and August 2024. Further work required to refine process in view of adverse events improvements.
	2.5	Policies and Procedures	Full review of the management and governance of policy and procedures across the organisation (with links to Inphase in view of the quality management system functionality for document control) Development of framework setting out the organisational policy and process for oversight and governance of policy/procedure	Clinical Effectiveness Manager	Dec 24	NHS Fife Policy and Procedure Framework currently out for consultation with key stakeholders. Scheduled for presenting to the Clinical Governance Oversight Group for endorsement in December 24.
	2.6	Medicines Safety Programmes	Ensure NHS Fife has a programme of continued improvement with medicines safety, including learning from incidents, quality improvement through a high risk medicines safety	Director of Pharmacy and Medicines Deputy Director of Pharmacy	Oct 24	The Safe Use of Medicines Group has evolved into the Medicines Safety and Policy Group, with a revised ToR and membership. A Medicines Safety Programme is underway,

			programme and education improvements, ensuring safe and effective prescribing.	Lead Pharmacist Medicines Safety		initial areas of priority are Diabetes medicines, Sodium Valproate, Lithium, Anticoagulants and High Risk Pain Medicines.
Enablers	3.1	Datix Replacement	A national tender has identified Inphase as the preferred system to replace Datix. It is likely that this system will be progressed and will provide wider benefits due to the quality management system functionality available	Associate Director for Risk and Professional Standards	Mar 25	Implementation group to oversee move from Datix to Inphase in place from October 24. Timescales for move not confirmed but likely to be early in 2025.
	3.2	National Early Warning Score (NEWS2)	NEWS2 rollout is being led by D&I supported by Deteriorating Patient Clinical Lead, Deteriorating Patient Resuscitation Lead, to be implemented within the next 12 months. There is a requirement to support this work through a clinical Reference Group	Associate Director Q&CG, Head of Programmes for D&I and Deteriorating Patient Clinical Lead	Mar 25	Project Group in place from September 24 and project plan being developed. Update paper defining approach for change scheduled at Clinical Governance Oversight Group December 24.
	3.3	Planning for Clinical Governance Strategic Framework Refresh	Engaging with the organisation to refresh the framework Explore with key leaders the scope for development of a Quality Framework, building on the Quality Network, to complement the framework	Associate Director Q&CG	Mar 25	Work to commence October 24

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Cancer Framework & Delivery Plan Update**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Kathy Nicoll, Cancer Transformation Manager**
	Dr Shirley-Anne Savage, Associate Director for Risk & Professional Standards

Executive Summary

- The NHS Fife Cancer Framework Delivery Plan update is being presented to the Clinical Governance Committee for **assurance,** updating the committee on the achievements to date against our agreed commitments.
- This Framework aligns with the national Cancer Recovery Plan, Cancer Strategy for Scotland 2023-2033, Population, Health and Wellbeing Strategy.
- Though extensive engagement with patients, public, staff and 3rd sector, the framework was developed to ensure that we can make a difference to how cancer services are delivered in Fife, ensuring it remains contemporary and reflects strategic changes both locally and nationally.
- The actions and achievements are reviewed on an annual basis to ensure objectives agreed can be delivered by 2025.
- Eight commitments were identified which are supported by key priorities which we aim to achieve by 2025. To date there is good progress seen in all areas of the Cancer Framework
- Work will continue to identify and progress actions for 2024-25 as well as refresh the 2022-25 Cancer Framework to extend beyond 2025 with alignment to the national Cancer Strategy for Scotland 2023-2033.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Legal requirement
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board / IJB Strategy or Direction / Plan for Fife
- NHS Fife Board Strategic Priorities
    - To Improve Quality of Health & Care Services
    - To Deliver Value and Sustainability
    - To Improve Health & Wellbeing
    - To Improve Staff Experience and Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Cancer Framework Delivery Plan update is being presented to the Clinical Governance Committee for **assurance** updating the committee on the achievements to date against our agreed commitments.

2.2 Background

This Framework aligns with the national Cancer Recovery Plan, Cancer Strategy for Scotland 2023-2033, Population, Health and Wellbeing Strategy.

Though extensive engagement with patients, public, staff and 3rd sector, the framework was developed to ensure that we can make a difference to how cancer services are delivered in Fife, ensuring it remains contemporary and reflects strategic changes both locally and nationally.

The actions and achievements are reviewed on an annual basis to ensure objectives agreed can be delivered by 2025.

2.3 Assessment

Eight commitments were identified which are supported by key priorities which we aim to achieve by 2025. To date there is good progress seen in all areas of the Cancer Framework

Commitment	No. Actions (inc sub actions)	No. Actions Progressed
Commitment 1: To reduce cancer incidence, mortality and inequalities for our population through effective prevention, screening and early detection initiatives.	12	11
Commitment 2: The patient will be at the heart of how services are designed with excellent patient experience	11	10
Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal and integrated pathways to deliver high quality cancer care	8	6
Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population	10	3
Commitment 5: Digitally enabled for sustainable and efficient service models which embrace technology and innovation.	14	13
Commitment 6: Recognise workforce challenges and identify system-wide approaches to support in relation to wellbeing, education and training to ensure our patients receive the best care.	9	5
Commitment 7: Ensure our healthcare environments are designed to deliver optimum patient care	4	3
Commitment 8: To make best use of available information sources to assure patients are receiving timely, high quality, effective care	6	6

As the Cancer Framework remains a working document with a rolling workplan, actions and improvements are part of an iterative process; whilst progress is being made, each action is under review annually. There are many pieces of work ongoing that pertain to specifically to cancer but also as part of wider strategies where cancer services are impacted and review of commitments and actions will continue. Please see appendix 1 for full report.

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

Next Steps

We will continue to identify and progress actions for 2024-25 as well as refresh the 2022-25 Cancer Framework to extend beyond 2025 with alignment to the national Cancer Strategy for Scotland 2023-2033.

2.3.1 Quality, Patient and Value-Based Health & Care

The development of the Framework aims to improve outcomes, patient experience and sustain cancer services.

2.3.2 Workforce

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

2.3.3 Financial

Financial implications are considered through the Framework development.

2.3.4 Risk Assessment / Management

5 risks have been identified. The risk relating to the Edinburgh Cancer Centre has been temporarily closed due to the expected pause in the project. Macmillan has agreed to fund for a programme of works to pick up on aspects of the previous ECC IA with a scope to review sustainable workforce, patient choice/information, use of innovation, education and training. Project team to be recruited. This risk will be updated as required.

Risk	Description				
Cancer Framework - Cancer Workforce	There is a risk that we will be unable to deliver the Cancer Framework within the stated timescales due to: demand for cancer services not keeping up with the rate of growth of staffing, lack of succession planning, inability to recruit suitably trained staff to vacant posts, national shortages of specialist posts and posts not being funded substantively, resulting in sub optimal patient experience and outcomes, increased pressure on staff and services and adverse publicity.	3 - Possible - May occur occasionally - reasonable chance	5 - Extreme	High Risk	15
Cancer Framework - D&I Challenges	There is a risk that lack of investment in digital and information to support cancer services will impact on our ability to deliver key commitments identified in the framework in relation to optimal pathways and integrated care, digital exclusion for those without access and robust quality and performance improvement data collection systems resulting in non-integrated care and unequal access to information	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12
Cancer Framework - Financial Delivery of Cancer Framework	There is a risk that we will be unable to deliver the Cancer Framework due to insufficient financial investment in Cancer Services and funding being provided on a non-recurring basis resulting in disruption to / loss of services, sub optimal patient experience and clinical outcomes, and adverse publicity.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	Moderate Risk	12
Cancer Framework - Cancer Services Property & Infrastructure	There is a risk that we will be unable to deliver the Cancer Framework due to inadequate space/capacity to accommodate the current demand and expected increase in patients with a cancer diagnosis and with extended active treatment times, resulting in sub optimal patient - care, experience, outcomes and safety.	2 - Unlikely - Not expected to happen - potential exists	4 - Major	Moderate Risk	8

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

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

2.3.6 Climate Emergency & Sustainability Impact

Through implementation of the framework we will work with colleagues to ensure we are cognisant of more sustainable, greener healthcare.

2.3.7 Communication, involvement, engagement and consultation

This report has been discussed with:

- Associate Director for Risk and Professional Standards
- Lead Cancer Nurse
- Strategy Manager, D&I
- Consultant, Public Health
- Assistant Research, Innovation & Knowledge 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.

- Cancer Leadership Team Meeting, 21 May 2024
- Cancer Governance and Strategy Group, 14 August 2024
- Executive Directors' Group, 17 October 2024

2.4 Recommendation

Members are asked to note the achievements from the Cancer Framework to date and take a **"moderate"** level of assurance.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Draft NHS Fife Cancer Framework Update Year 1 & 2

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Cancer Framework

Annual Update Overview
Year 1 & Year 2

For the population of Fife we will deliver effective cancer prevention, early diagnosis and high quality sustainable cancer services for those living with and beyond cancer.

2022–2025

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Introduction

How are we doing?

The Cancer Framework closely aligns with the NHS Fife Population, Health and Wellbeing Strategy which was published in 2023 and the Cancer Strategy for Scotland 2023-2033 and 3 year Action Plan published by Scottish Government in July 2023.

The NHS Fife Cancer Framework was published in 2022. This report aims to show achievement against our commitments and the excellent progress that has been made across all areas. There have been ongoing pieces of work in the background that have not been identified as specific actions in the Cancer Framework Annual Delivery Plan however have also been captured to demonstrate alignment with other strategies.

Each year the commitments are reviewed to ensure they remain relevant and up to date and that effective cancer services continue to be delivered. Some of the actions agreed are part of wider strategies however impact on the delivery of cancer services.

What next?

We will continue to identify actions for 2024-25 as well as refresh the 2022-25 Cancer Framework to extend beyond 2025 to confirm alignment with the Cancer Strategy for Scotland 2023-2033.

Our cancer commitments

Prevention early diagnosis and reduction in inequalities

Commitment 1: To reduce cancer incidence, mortality and inequalities for our population through effective prevention, screening and early detection initiatives.

To deliver this commitment the priorities identified for reducing cancer incidence, mortality and inequalities in Fife are:

1.1. Reduce the harms associated with preventable risk factors for cancer, with a focus on supporting healthy communities, early and targeted intervention, effective and integrated harm reduction and reducing inequalities. Key priority areas are:

1.1.1. Develop a system wide approach in collaboration with Health Promotion to focus on promoting holistic assessments of patient's risk for the cancers which are attributable to life style across hard to reach groups e.g., Making every contact count.

Year	Progress
Year 1 (2022-23)	Health Promotion provide a suite of training and advice through Good Conversations, helping adults to choose change rehabilitation videos, reduce or stop drinking and smoking prior to hospital admissions to reduce risk during hospital stay and surgery complications.
Year 2 (2023-24)	Good Conversations training has been rolled out to RCDS and SPOCH

1.1.2. Promote good community orientation through improving awareness.

Year	Progress
Year 1 (2022-23)	Health Promotion Service contributes through routine awareness of access to the system of resources available including signposting and links to services and support locally and nationally Health Promotion resources including IRC, training, targeted campaigns and health topics etc are promoted regularly through local community planning and partnership groups. forums and with priority groups. For example, input to Fife College to raise awareness of lifestyle risk factors of cancer with 16-24 year olds (alcohol, food and health and addictive behaviours). Work is also underway to test approaches to promote health topic information and key campaigns such as Right Care Right Place in local community settings working, and this will be developed during 2023.
Year 2 (2023-24)	As well as Physical Activity strategy, Health Promotion has supported the development of a Food4Fife strategy. There have also been good outcomes observed in localities around physical activity.

	Continue to provide health promotion materials to the community e.g. on healthy behaviours, through NHS Fife website, The Well etc. Health promotion team is working to improve lifestyle factors that support a healthier population. Key commitments include reducing rates of smoking and alcohol consumption as well as encouraging exercise and promotion of healthier eating

1.1.3. Support the public, patients and staff to eat well, have a health weight and be physically active.

Year 1 (2022-23)	There have been several meetings of key partners progressing the actions in Fife Physical Activity Strategy. Food and Health work has been progressed and a number of programmes. For example, provision of training to upskill knowledge and understanding of healthy eating behaviours and build capacity within community (Food Champion training). Provision of training to raise awareness of impact of healthy eating and exercise and link to cancer to increase knowledge and understanding and build capacity within Early Years staff (HENRY). Due to reduced capacity the Physical Health Activity has not progressed as intended. Work being progressed to establish a short life working group to review pathway and data capture.	
Year 2 (2023-24)	Support delivery of the Prevention and Early Intervention Strategy	Prevention and early intervention strategy not yet finalised but close to sign off - now expected in May 2024. *c/f 2024-25*
	Work with Community and Wellbeing Partnership on delivering against (ambition 3) of the plan for Fife	Maintain focus on relevant areas of the Communities and Well-being Delivery Plan including a plan of action for local delivery of Public Health Priority 6, Food 4 Fife Strategy and Physical Activity and Sport Strategy. *c/f same narrative for 24/25*

1.1.4. Reduce harm associated with tanning practices in our community.

There have been no specific tanning initiatives in Fife however Sun Awareness Week occurs in May (6-24 May 2024) and the national campaign runs from April to September; there is specific advertising/advice on our NHS Fife website Sunscreen and sun safety - NHS (www.nhs.uk)

1.2. Protect people from cancer through HPV vaccination, maintaining immunisation coverage rates and reducing inequalities in coverage in line with the Fife Immunisation Strategic Framework 2021-24.

Year 1 (2022-23)	Achieve HPV immunisation coverage of 85% for females by end of S3 across SIMD.	HPV programme has changed from 2 dose to 1 dose schedule, therefore dose 1 now indicates completed course / fully vaccinated (https://www.sehd.scot.nhs.uk/cmo/CMO(2022)35.pdf) HPV dose 1 immunisation coverage rates for S3 in Fife schools for 2021/22 academic year met overall 85% target (89% females; males 83%; both sexes 86%). SIMD data provided for both sexes only: SIMD 1 (most deprived)

		uptake =79%; SIMD 5 (least deprived) uptake = 93%. End S4 SIMD 1 uptake = 91%; SIMD 5 = 93%. Propose revise the outcome target for 2022/23 school year (reporting in 2023/24) in line with WHO cervical cancer elimination goal for 90% females vaccinated by age 15: - Proposed wording for description: Sustain and improve HPV dose 1 coverage rates across Fife for both sexes. - Proposed wording for outcome: Achieve HPV dose 1 immunisation coverage of 90% for females by end of S4 in Fife. Achieve 85% uptake by end S4 across all SIMD quintiles for both sexes by end S4.

1.3. Review the impact of the Fife Rapid Cancer Diagnosis Service (formerly known as Early Cancer Diagnosis Centre (ECDC)) for those with vague symptoms with a view to expanding to other specific tumour sites.

Year 1 (2022-23)	Explore expansion of RCDS principles to other Urgent Suspicion of Cancer (USOC) pathways.	Expansion of the principles of RCDS TOC within UGI and HPB - live in January 2023 Working on ARCT Interviewing for additional RCDS nurse Expanding to Colorectal 2023-24
	Scope potential for Community Pharmacy USOC referral involvement.	Proposal presented at the CGSG 13/01/23. Take proposal forward 2023-24
	Scope and understand population profile referred to Rapid Cancer Diagnostic Service (RCDS) (formerly known as Early Cancer Diagnosis Centre (ECDC))	Lead Cancer Nurse analysing data between June 21-Dec 21 to identify if any patients who were referred to RCDS have subsequently gone on to develop a cancer. Have identified the headers required. Requested a report to be created- expected mid-January
Year 2 (2023-24)	Implement a cancer education package for Community Pharmacy around red flag symptoms and for patients on cancer treatment.	Education event for community pharmacy teams is being planned to take place in March 2024. This will include early warning signs and symptoms, good conversation skills and current referral pathways.
	Explore pathways available to community pharmacy for referral with warning symptoms	Continuing to explore the possibility of access to SCI Gateway in community pharmacy with Digital colleagues as the first step in potential referral pathways.
	Expansion of RCDS principles through Test of Change	The Upper GI/HPB Test of Change commenced in January 2023. The UGI test of change utilised a nurse led model, coordinating of triage and diagnostic (endoscopy/radiology) tests processes in the diagnosis of USC GI/HPB cancers ensuring timely triaging and vetting of Urgent Suspicion of Cancer (USoC) referrals. A General Surgery Nurse-led vetting pathway was created on TrakCare to ensure referrals are directed straight to nurse-led vetting. This ToC was successful and is included in RCDS core services at no additional cost. Written report of Test of Change is currently being finalised

1.4. Work with partner organisations across the whole system to address the broader upstream determinants of health that contribute to cancer inequalities.

Working with strategic partners to develop and deliver Plan for Fife- which is focussing on tackling poverty and inequality and brings together key partners including Fife Council, the voluntary sector and NHS Fife.

1.5. Embed a culture of 'prevention' and 'mitigating inequalities' into routine services, increasing staff awareness and capacity to intervene early with regards to risk factors for cancer.

Development is underway of a prevention and early intervention strategy which is expected to be signed off by summer 2024. This aims to improve overall public health and wellbeing by preventing or limiting impact of disease and other social problems

1.5.1. Increase health professionals' awareness to promote the Health and Social Care Partnership (HSCP) Reduce the Risk of Cancer leaflet by providing key messages to share and signpost information of the key preventable risk factors for cancer.

Reduce the Risk of Cancer: a guide for professionals was published in 2021 and designed by Health Promotion. This document was widely circulated (and linked) at the point of the publication of the Cancer Framework

1.5.2. Build on work to increase advice and support relating to income maximisation for cancer patients.

Macmillan ICJ support people with financial concerns and work in partnership with the Citizens Advice and Rights Fife (CARF), Macmillan Welfare Support Officer. Face to face and virtual workshops have been delivered with local and national partners across all sectors. For example, (CARF) and the Child Poverty Action Group (CPAG). Some of the training delivered includes: - Fife Benefit Checker and Our Fife Toolkit workshops. - Money Talk workshops (specifically targeting Health Visitors, Family Nurses and Midwives as part of the Financial Inclusion Referral Pathway). - Poverty Awareness Information Session.

1.6. Ensure screening is easy to access, local and supported by appropriate resources to support patients to participate, with a focus on populations that have difficulty accessing screening to address inequalities in uptake.

The bowel screening update for all eligible men and women (aged 50-74) in 2020-2022 was overall 66.32% in Fife (66.23% in Scotland). The uptake in the most deprived areas of Fife was 55.6% and least deprived 74.8%. In 2023, a Screening Inequalities Action Plan was produced to address inequalities in screening, including cancer screening. The action plan was developed following engagement with a multidisciplinary stakeholder group across Fife. Some of the activities so far include:

- Screening presentation for minority ethnic group - African ladies in Fife.
- Ongoing Bridging the Gap Project work to improve participation in screening, among patients living with enduring mental health conditions.
- Working with the third sector, for example Corra Foundation to identify opportunities to reach local communities to promote cancer screening.
- Screening programme presentation and discussion at the International Women's Day event in March 2024
- The action plan to reduce inequalities in screening update is still ongoing

1.7. Ensure Primary Care Healthcare Professionals have appropriate and equitable access to diagnostic imaging and triage to support urgent suspected cancer referrals.

GPs do not have direct access to CT for suspected cancer patients; however there is a robust wraparound service through RCDS which provides access for GPs to support patients who present with vague symptoms or with a suspected Upper GI cancers.

Person-centred

Commitment 2: The patient will be at the heart of how services are designed with excellent patient experience

To achieve this commitment we will:

2.1 Actively include the views and experiences of patients, families and unpaid carers through continued engagement to ensure shared decision making, including Care Opinion.

Year 1 (2022-23)	Widely introduce Care Opinion across the cancer services to ensure patient feedback is incorporated into quality and safety improvement	Services now have QR codes for specific cancer sites. CNSs are Care Opinion owners. Specifically able to differentiate between HPB and UGI coming through RCDS. Good data from Care Opinion
	Cancer patients will be represented at cancer groups with a review undertaken to ensure appropriate representation and involvement	Patient representatives invited on to cancer groups. To continue patient engagement through the Cancer Framework and Delivery Plan
Year 2 (2023-24)	Ensure the cancer groups have appropriate patient representatives	The Cancer Governance and Strategy Group has patient representation on the group. Patient are invited on to project groups, e.g. Single Point of Contact Hub, Prostate Improvement Group.
	To develop a quality improvement model using the Cancer Experience Improvement Model (CEIM)	The implementation of the care experience improvement model was achieved across 4 cancer site, demonstrating varying degrees of success Insufficient allocation of human resource may hinder the effective sustained implementation of this model Urology is currently addressing adjustments regarding earlier access to the cancer clinical nurse specialist within the pathway. In addition changes were made around aftercare of indwelling catheters. Additionally other services have recognised and highlighted best practise within their services
	Introduction of volunteers within services to collect cancer Care Opinion feedback	Secured volunteers to obtain objective feedback from patients who were unable to undertake independent feedback.

2.2 Services will be designed to ensure there is a dedicated Single Point of Contact to provide information points for appointments, advice, clinical and other support.

Year 1 (2022-23)	Introduce a Single Point of Contact and Patient Digital Hub.	Service introduced 1/9/22. Successfully implemented for all patients referred urgent suspected and diagnosed with colorectal or urological cancers. Expanding into lung 2023-24

		Patient Digital Hub paused due to technical difficulties for services that overbook clinics.
	Evaluation of new service	6 month evaluation will commence February 2023. Patient questionnaire has been created. Baseline data has been received. To do a Staff patient questionnaire (GP and CNSs)
Year 2 (2023-24)	Expansion of Single Point of Contact Hub (SPOCH) into the Lung Service	Initiation of the pathway is supported by SPOCH. Patients with an abnormal CXR will be offered an urgent CT within one week (reduced from a 2ww)
	Further development of Colorectal services within the SPOCH	SPOCH support patients on a consultant pathway and work in collaboration with RCDS test of change and the CNSs to support patients referred USC or diagnosed with colorectal cancer A process is in place for SPOCH to manage the negative qFIT pathway
	Complete 6 month evaluation of SPOCH from launch.	Evaluation complete with very positive patient experience noted.

2.3 Improve sharing of quality information with patients and care providers through digitally enabled systems, e.g., Holistic Needs Assessments (eHNA) and Treatment Summaries, Digital Patient Hub. electronic Key Information Summaries (eKIS) in primary care including Palliative Care summaries.

Year 1 (2022-23)	Scope baseline of use of electronic Health Needs Assessment (eHNA) and improve the usage in Cancer Care through Cancer Nurse Specialist (CNS) training	Awaiting eHNA Service Level Agreement between HCSP and NHS Baseline for 2022. Target of increasing the offer to be carried forward into 2023-24
	Explore clinical dashboard metrics for CNS to scope and understand measures already in use	Urology has been identified a test site for CNS clinical dashboard
Year 2 (2023-24)	Embedded the Electronic Health Needs Assessment (eHNA) to increase referrals from Cancer Services to the Macmillan Improving Cancer Journey (ICJ) pathway to ensure patients with a cancer diagnosis have access to financial and benefits advice.	

2.4 Develop a Cancer Services website dedicated to helping *people* who face *cancer* learn about patient services.

Year 1 (2022-23)	Develop a Cancer Services website for the public to ensure access to information on specific cancer sites and learn about local, regional and National cancer Information	Cancer patient website updated: https://www.nhsfife.org/cancer/

2.5 Ensure patients have access to prehabilitation and rehabilitation for optimum fitness prior and post treatment

Year 1 (2022-23)	Delivery of a universal prehabilitation model in Maggies Centre, Fife for urology and colorectal cancer patients, building on the test of change to expand to all cancers	Up to end of September 2022 195 patients attended universal Prehabilitation. 77%of patients' self-report improvements This is being expanded into all cancer types.
Year 2 (2023-24)	Universal prehabilitation was introduced within lung cancer and across all cancer specialties. The funding has now ceased; however, Maggie's are keen to continue to offer this service to all cancer patients and their families. SCAN has set up a Prehabilitation Steering Group through Macmillan funding.	

2.6 Patient choice, spiritual belief and understanding must be central to the care received and delivered.

The Spiritual Care Team have been exploring the spiritual needs of those receiving palliative care in the community with a key component is learning from colleagues across health and social care working with this group of patients in their homes. This is expected to be written up in July. At this time, due to financial constraints, the Chaplain's funding for one day a week will end making it difficult to ascertain what can be received and delivered thereafter and implement any findings (primarily specialist spiritual care provision in the community combined with better equipped generalist provision to help families at the end of life).

2.7 Ensure optimal pathways exist to ensure efficient diagnosis and treatment of patients.

Year 2 (2023-24)	Implementation of Optimal Lung Cancer Pathway	Steps have been taken to reduced waits between steps through the Optimal Lung Cancer Pathway Group CXR - same day/next day CT - within 7 days and 24 hour turnaround reporting Vetting - same day 1st OPA - challenges due to paternity leave. Locum started December. Aim to improve waits MDT - changing clinics and bronchoscopy lists around have reduced MDT discussion from an average of 11 days to an average of 6.5 days between last test. c/f 2024/25
	Review Head & Neck Optimal Pathway	Non-recurring funding has been confirmed for £10,000 for 2023-24 to support radiology (staging CTs) and 24 hour turnaround. To work with service to review pathway

2.8 Ensure care is close to home where possible, repatriating care from out with Fife, where appropriate.

Work is ongoing to determine the feasibility of repatriating breast screened patients from NHS Lothian.

Near Me appointments are offered through RCDS and as required.

Oral SACT for prostate patients is delivered in a community setting

2.9 Review transportation and financial support for patient access to services both within and out with Fife.

RCDS and SPOCH patient navigators support better access and better outcomes for those living in poverty by ensuring transportation is available and booked for appointments. The patient navigators also refer to ICJ and Maggie's where appropriate so a financial assessment can take place.

2.10 Make returning to work after a cancer diagnosis a health outcome, including signposting and awareness of public and 3rd sector organisations that support return to work after illness such as Access to Work, Fife Employment Access Trust (FEAT) and Healthy Working Lives.

The Faculty and Society of Occupational Medicine both fully support "Work is a Health Outcome" initiative in all their policies nationally and locally. Macmillan Improved Cancer Journey (ICJ) do not support people back to work directly however they review and find out what support is available, contacting relevant resources, e.g. Disability Employment Service, Disability Team FC, Supported Employment Service, FEAT and Access to work.

2.11 Continue to offer patients support through the Macmillan Improved Cancer Journey (ICJ) pathway to ensure they can access support as their circumstances change.

Year 2 (2023-24)	Signpost/refer patient to Macmillan Improved Cancer Journey (ICJ)	RCDS and SPOCH Patient Navigators have had the appropriate training are able to refer patients to Macmillan ICJ and Maggies Fife

Optimal pathways and integrated care

Commitment 3: Patients will receive the right treatment at the right time in the right place by the right person. This will be delivered through the development of optimal and integrated pathways to deliver high quality cancer care.

To achieve this commitment, we will:

3.1 Implement sustainable optimal cancer pathways with review of timed cancer pathways to improve cancer waiting times performance and to ensure clear timelines for appointments, diagnostics, decisions and treatments, including direct patient navigation for the most complex patient pathways from initial referral through to palliative and end of life care.

Year 1 (2022-23)	Prioritised review of optimal and timed cancer pathways (Colorectal, Lung, Gynaecology, Urology).	Identified prostate and lung as prioritised pathways for review Prostate Project Group set up. To look at a nurse-led pathway to MDT - CRUK TET funding secured to support review. Optimal Lung Pathway funding for 2022-23. Scoping current resource and expected requirements. To carry forward beyond March 2023
Year 2 (2023-24)	Achieve additional capacity for access to the 3 key radiology diagnostic tests (MRI, CT and U/S) to maintain 2 week targets for cancer referrals	2 week referral to report target consistently achieved
	Ensure routine adherence to Scottish Cancer Network Clinical Management Guidelines for CMPs through MDT.	CMPs for lung, breast and neuro oncology published. Next publication will be prostate and head & neck. Continued used of regional CMGs
	Put in place Breach Avoidance and Effective Breach Analysis SOP	Management of patients referred urgent suspected cancer or diagnosed with cancer Standard Operating Procedure has been updated to incorporate breach avoidance and breach analysis.
	Implementation of Regrading Guidance	Advice sought from clinical colleagues regarding regrading habits. This shows variable processes across all specialties. GPs are advised of a downgrade sporadically and the patient was rarely advised. Action for 2024-25 to be agreed.
	Expand diagnostic capacity to support cancer services	Cancer referrals are prioritised across radiology and endoscopy

3.2 To embed a new model for Specialist Palliative Care, to optimise generalist palliative care access and provision in acute and community settings; to develop a Best Supportive Care (BSC) pathway with care that is multidisciplinary, integrated and coordinated; improving Primary Care, Acute Care and Specialist Palliative Care linkages.

Year 1 (2022-23)	Specialist Palliative Care and Primary Care will collaborate to model a best supportive care (BSC) pathway for Fife	Ongoing work. NEF Cluster showed no interest in QI work. Awaiting further info on funding opportunities from the Board Deputy Medical Director. Considering engagement with regional Primary Care Palliative Care leads to propose and agree standards. Pilot ongoing to use standardised template to communicate between Lung cancer nursing team and Primary care. The Palliative Care Consultant and Lead Cancer GP have been invited to present Fife BSC developments at British Gynaecological Cancer Society conference and to NHS Grampian cancer conference. A Best supportive care leaflet is being developed. All CNSs will be expected to roll out the same documentation. Working closely with colleagues in Lothian Pathways will be further developed in 2023-24
	Develop models of prescribing and supply of palliative care medicines	Access to palliative care medicines in the community - The palliative care community pharmacy agreed stocklist has been reviewed and updated to reflect the demand for the palliative care medicines in the Community. The palliative care outreach team have a HBP prescription pad to access palliative care medicines for community patients via the Community Pharmacy Palliative care medicine expenditure 2021-22 - This was reviewed in August 2022 and there were no concerns. Just in case box medicines The NHS Fife just in case box policy is currently being reviewed and it is anticipated that the new version of the policy will be launched in Summer/Autumn 2023. *c/f further actions 2023-24* Palliative care medicines prescribing - The NHS Fife Palliative Care Pharmacist is developing a dose-escalation palliative care Kardex which is currently being reviewed and going through the approval process. *c/f further actions into 2023-24*
Year 2 (2023-24)	Specialist Palliative Care and Primary Care will collaborate to model a best supportive care (BSC) pathway for Fife	The BSC Lung Pathway work has been completed and is currently out for consultation.

		There is an expectation that it will form the foundation for other pathways.
	Develop models of prescribing and supply of palliative care medicines	Just in case policy review has been undertaken and this has been updated and is currently going through the approval process. Significant education and training is required. Proposed implementation date is summer/autumn 2024. *c/f 2024-25* The NHS Fife Palliative Care Pharmacist is developing a dose-escalation palliative care Kardex which is currently being reviewed and going through the approval process. This has been put on hold until the just in case policy is implemented and will be picked up again after this. *c/f 2024-25*

3.3 Develop Systematic Anti Cancer Treatment (SACT) models to ensure patients are treated in the most appropriate setting.

Year 1 (2022-23)	Develop a plan for repatriation of SACT to VHK	Part of the work of the Ambulatory SLWG to repatriate SACT from QMH to VHK. Space identified at VHK. Discussion ongoing regarding refurbishment. Oral SACT is delivered in an outpatient setting and community settings.
Year 2 (2023-24)	The SACT Unit was successfully repatriated to VHK. Discussions are ongoing to relocate the SACT Unit to meet current and increasing demand. *c/f 2023-24*	

3.4 Review the contribution of the wider workforce for continuing care and utilise all the workforce to ensure that every contact counts.

3.5 Ensure effective design of Multidisciplinary Team (MDT) meetings to optimise on early diagnosis and timely treatment and care, fostering a culture of strong leadership and teamwork across all services.

All MDT outcomes are completed same day, emailed to the GP and uploaded to SCI Store ToRs for Breast and Lung cancer MDTs have been reviewed and updated. A regional review of the urology MDT constitution has been undertaken – awaiting outcome.

3.6 Ensure that prehabilitation and rehabilitation are embedded in care pathways.

Year 2 (2023-24)	Embed the universal offer of Prehabilitation into Maggies	Universal offer of Prehabilitation available for all lung cancer patients and across other cancer specialties.

3.7 Actively engage with Edinburgh Cancer Centre in relation to opportunities in Fife.

The ECC Outline Business Case is currently paused. However close engagement with NHS Lothian continues in respect of regional, cancer site specific and management meetings. Repatriation of breast screened patients is currently underway. There is a requirement to focus on workforce challenges in relation to visiting oncologists into 2024-25.

3.8 Focus on equality when planning and designing new cancer related services to avoid and reduce the impact of social inequalities in accessing cancer services including screening, diagnosis, treatment, information, support and clinical trials.

Year 2 (2023-24)	Data and intelligence on primary care cancer referrals, including on inequalities in access to services.	Gain agreement from cancer leadership, cancer governance teams, primary care leads and GP cluster leads to produce a report on cancer referrals by GP clusters. Now completed.

Research, Innovation & Knowledge

Commitment 4: Research, innovation and knowledge is central to the delivery of high quality sustainable cancer services for our patients and population.

To achieve this commitment, we will:

4.1 Explore a Hub and Spoke model of care to ensure equitable access to clinical trials with care closer to home.

Year 1 (2022-23)	Seek suitable Clinical Trial of Investigational Medicinal Product CTIMPS with regional partners (Lothian, Tayside) to trial hub and spoke and other models.	Recruitment of breast oncology research nurse. Consultant interest in acting as PI for prostate cancer studies. Continue to seek opportunities within the cancer environment.
	Consider legal requirements for supply of clinical trial medicines.	All legal requirements are being met for current cancer trials. No trials have been set up yet using the hub and spoke model

4.2 Improve links with East Region Innovation Hub.

Year 1 (2022-23)	Share cancer related innovation opportunities and liaise with relevant clinicians, academics, industry	Opportunities identified. To take forward in the New Year NHS Fife has been approached to join regional partners in Health Innovation South East Scotland (HISES) to collaborate on a regional bid for Scotland's optimal lung cancer diagnostic pathways, addressing the deficiencies at the diagnostic end of the pathway. This is a £3M fund from the Scottish Government. Innovation Manager forwarded the call onto relevant colleagues in NHS Fife for awareness.
Year 2 (2023-24)	Whilst there is not many innovations NHS Fife can currently link into, there is excellent collaborative working with the East Region Innovation Hub with representation at bi-monthly and quarterly meetings with links into pipeline work and are as connected as possible with any cancer activity. A regional Academic Liaison Group (Borders, Fife and Lothian) and five universities (including St Andrews) has been set up to look at opportunities in cancer to ensure active horizon scanning. This will continue into 2024-25. Ongoing challenges around financial support from Cancer Research UK (CRUK) as funding has been severely limited. Lothian have been able to pump prime however due to current financial challenges this has now ceased.	

4.3 Understand the cost benefits of improved clinical trial participation.

This is embedded practice when recruiting patients to clinical trials. NHS Fife ensure there is a mixed portfolio with active relationships with NHS Lothian around access to ChemoCare scripts for patients on trials in Fife only however due to staffing challenges in Lothian trials are now limited to those carried out in Lothian as well.

4.4 Embed research into standard work through the research, innovation and knowledge programme of education.

This is business as usual. There is an ongoing rolling programme of education and training.

4.5 Ensure staff have the appropriate time allocated to acquire knowledge of new treatments.

Time allocated sits within services however RIK will support staff as appropriate, share information and outcomes. RIK publish regular local newsletters informing the organisation of ongoing and new work.

4.6 Support healthcare professionals to be innovative in pursuing continuous quality improvement, prioritising tests of change to support early diagnosis and wider best practices from successful research studies.

There are access routes for RIK support for healthcare professionals.

4.7 Align with the NHS Fife Innovation governance Framework to ensure new innovations are appropriately planned, resourced and monitored.

A process is in place and is now live. An Innovation Review Project Group (IRPG) has been set up to review potential projects with staff across the organisation

4.8 Seek opportunities to test innovative solutions with the McKenzie Early Diagnosis Institute and the South East Health Innovation Hub (HISES).

Year 2 (2023-24)	Horizon scan for funding applications and/or innovation challenge/catalyst calls	NHS Fife have worked with partners in the Southeast Innovation Hub, HISES, and the Southeast Cancer Innovation Governance Group to horizon scan for suitable funding calls or catalyst challenges. This includes looking at Scottish Government SBRI Challenges, UKRI funding calls, innovation for invention (i4i) calls and charitable funding for innovation.

	Collaborate with McKenzie Early Diagnosis Institute and/or HISES to submit applications or support successful submissions	To date no funding calls have been suitable for NHS Fife to collaborate on with the McKenzie Early Diagnosis Institute and/or HISES. Once a suitable funding call is identified NHS Fife will work with colleagues in other organisations to fully support the application and successful submission.

4.9 Work closely with our educational partners.

NHS Fife are actively connected with St Andrews University. Applying for joint funding and working on research projects. This work will carry on into 2024-25.

4.10 Align work with Public Health to reduce inequalities in research.

There are Realistic Medicine representatives in the Innovation Review Project Group. Reducing inequalities and improve access is part of the overarching priorities for RIK.

Our enablers

Digital and Information

Commitment 5: Digitally enabled for sustainable and efficient service models which embrace technology and innovation.

To achieve this commitment, we will:

5.1. Develop cancer clinical information systems that:

5.1.1. Track patients referred with urgent suspected cancer or diagnosed with cancer.

Year 1 (2022-23)	Explore robust tracking solution to support effective and efficient patient tracking.	MORSE identified as a potential solution. Prototype developed. Service Work package completed for AST. Quote to be sought from CAMBRIC followed by development of a business case. Wider exploration of a shared solution across SCAN - not feasible. C/F 2023-24
Year 2 (2023-24)	Explore robust tracking solution to support effective and efficient patient tracking.	A business case has been developed and a quote supplied (£13,425.90). Funding is required to support an updated system however there is no funding identified. The current system works adequately however this is not supported by D&I SBAR by D&I regarding funding which is to be taken through the relevant governance groups c/f 2024-25

5.1.2. Provide a Multidisciplinary Team (MDT) solution which is fit for purpose.

Year 2 (2023-24)	Provide a Multidisciplinary Team (MDT) solution which is fit for purpose	Use of Apps identified as a potential solution. This is currently used for regional MDTs. Scoping requires to be carried out by D&I to explore if this would be a suitable solution for NHS Fife. Morse is cited as an alternative solution c/f 2024-25

5.1.3. Manage and monitor activity, for example inpatient SACT and HPB surveillance.

5.2. Support the improvement of the cancer referral process through:

5.2.1. Implementation of Fife Referral Organisational Guidance (FROG).

Year 1 (2022-23)	Introduce Fife Referral Organisational Guidelines (FROG)	Live: https://app.joinblink.com/#/hub/46c35009-f9d3-45cd-b0fd-a1a0f006f701

5.2.2. Introduction applications ('Apps') to support referral, e.g. photo triage, in a secure and compliant manner.

Year 1 (2022-23)	Introduce patient access to information and patient initiated review	GPs use Pando App to take photos and attach to skin lesion referrals. Photos are enabling active triage and downgrading as reported.

5.2.3. Prepare for the implementation of nationally provided artificial intelligence (AI) to support early detection.

Year 2 (2023-24)	Work with Bering on an AI assisted tool, e.g. (BraveCX) to pick up lung cancer early from chest x-rays	There are a number of AI assisted diagnostics projects on the go, one of which involves a Lothian clinician, who is a HISES Clinical Innovation Fellow. Discussed NHS Fife being a pilot site contributing to that but was too difficult to set up. No other AI cancer related projects in HISES at this point. Initiative led from NHS Grampian, once any of these reach the ANIA stage of national adoption, a process will be in place that supports consideration of implementation – actual implementation wouldn't sit with Research, Information and Knowledge.

5.2.4. Implementation of Acute Clinical Referral Triage (ACRT) and Patient initiated review (PIR).

Year 1 (2022-23)	Introduce patient access to information and patient initiated review	PIR introduced in the breast service, releasing capacity to see more new patients (referrals have significantly increased). Routes back into service should patients see changes. In line with other Boards. Patients still receive annual mammogram.
Year 2 (2023-24)	Introduction of Active Clinical Referral Triage (ACRT)	ACRT will not be used where there is a suspicion of cancer however this has been progressed in many services for regraded or non-cancer related referrals.

5.3. Ensure information is available to patients and staff to improve their patient journey and outcomes:

5.3.1. Development of a cancer webpage for staff and patients to access up to date, relevant information.

Year 1 (2022-23)	Develop a Cancer Services website for the public to ensure access to information on specific cancer sites and learn about local, regional and National cancer Information	Cancer patient website introduced: https://www.nhsfife.org/cancer/

5.3.2. Development of information resources, e.g. electronic treatment summaries, palliative performance scale.

A Palliative Care Cancer Summary (PCCS) and guidance has been introduced to ensure important communications reach our primary care colleagues the same day and provides an overview of patient's social situation, diagnosis, treatment plan, follow up plans, relevant comorbidities and includes any current issues, future planning and action for the GP or DN or wider professionals and phase of illness. This is updated, uploaded and available in the Clinical Portal.

5.3.3. Implementation of Electronic Health Record (EHR).

EHR is being implemented by wider digital teams with a meeting arranged to agree priorities, e.g. Nursing and Inpatient record or ED record first for digitisation, in the meantime scanning continues which will be complete for all areas by 2025.

5.4. Support the change by:

5.4.1. Ensuring the reduction of digital exclusion in the design of solutions, with particular consideration of people without access to data, devices, digital literacy and disabilities which may affect use of digital options.

Year 1 (2022-23)	Develop a Digital Patient Hub in RCDS	Unable to introduce the Digital Patient Hub in SPOCH as the services is required to overbook appointments to ensure patients are seen within 14 days. Patient Digital Hub under development for RCDS as this service does not overbook. Due to the nature of the service, patients will not be able to cancel in the App and will be required to telephone. Expect go live January 23 Technical issues have resulted in this action being carried forward into 2023-24
Year 2 (2023-24)	[New] Roll out Digital Patient Hub	Digital Patient Hub has been rolled out in urology, ENT, gynaecology, and general surgery includes appointments from those referred urgent suspected cancer.

5.4.2. Ensuring the availability of the Digital Enablement team to support both patients and staff with their adoption and use of digital systems.

Staff are able to access training through IT Helpdesk Patients can seek support in the use of NHS Fife digital systems through the Digital Enablement Team. This team will also attend hubs such as Men's Shed or the Rotary Club, for example.

5.4.3. Ensuring the solutions are safe and secure by meeting both clinical and information governance standards.

Any new solutions are subject to Network and Information Systems Directive (NSID) controls

5.4.4. Ensuring appropriate cancer data is available for reporting in support of operational improvement and strategic planning.

Cancer data is available through Business Object reporting. Information support the Cancer Audit Team in the development of ad hoc and routine reporting.

Workforce

Commitment 6: Recognise workforce challenges and identify system-wide approaches to support in relation to wellbeing, education and training to ensure our patients receive the best care.

To achieve this commitment, we will:

6.1. Review the cancer workforce, including skill mix and supporting roles, to inform future service delivery models and succession planning.

Year 1 (2022-23)	Undertake AO/SACT (including clinical and technical pharmacy) workforce review.	Confirmed recurring funding of £103k. Focussing on SACT in the first instance. SCAN to invoice then send recurringly thereafter. Specialty Doctor, Scheduler and admin support
	Review MDT and Tracking resource	13/12/22 - submitted to SAS for onward discussion with CMcK - await outcome. Posts secured non-recurringly beyond April 2023 and under review. Funding secured to March 24
	Undertake urology cancer nursing workforce review	Macmillan Skills Matrix rolled out to all PNs in both Services and SPOCH
	Support staff retention and wellbeing through Values Based Reflective Practice (VBRP)	Open to CNS and PNs. Funding only available until March 23.
	Explore funding for the continuation of VBRP	Utilised for 2022-23. No funding available beyond March 23
Year 2 (2023-24)	Support the national Oncology Transformation Programme. Explore staffing levels in the SACT Unit to support demand now and in the future.	SACT Capacity Tool showed chair utilisation at 217%. Identified staffing requirements of an additional 2.8wte to current establishment. Staffing scoping exercise carried out to determine safe staffing requirement and includes the recruitment of additional ANPs Recurring AO/SACT funding confirmed for 2023-24 of £205,570. Funding used for Band 3 SACT Scheduler, Specialty Doctor, 2.0wte Band 7 ANPs, Uplift of Band 6 to Band 7 Acute Oncology

6.2. Work towards the national agenda to transform roles with consideration of Senior Professional Leadership, Management of CNS, ANP and AHP workforce being aligned to support the broader vision and developments.

Year 1 (2022-23)	Promote early engagement with local transforming nursing roles programme	Awaiting recruitment within the nursing directorate To carry forward into 2023-24
	Scope and assess existing competency and role parameters for CNSs within cancer services	Complete

Year 2 (2023-24)	Promote early engagement with local transforming nursing roles programme	Developed Annexe 21 job descriptions for cancer clinical nurse specialists.

6.3. Review wider roles, such as AHPs and palliative care to complement an integrated cancer care pathway. Ensure the wellbeing and resilience of the cancer workforce including improved access to Spiritual Care and other wellbeing services as part of the approach to staff wellbeing.

Year 2 (2023-24)	Improve Physiotherapy and Occupational Therapy support for Hospice and Community Specialist Palliative Care	Staffing is less that optimal however the services are linking in with the redesign work, which is evolving well and already showing benefits to the patient experience.
	Embed Psychological Therapies Framework into Cancer Services.	Link into the Macmillan steering group which will be benchmarking and scoping of opportunities to increase the provision of these services against the four levels of support identified in the Psychological Therapies and Support Framework for People Affected by Cancer. Psychological support is already embedded within our cancer services. Rapid Cancer Diagnostic Service (RCDS) and other services complete Holistic Needs Assessments and make referrals to Maggie's Centre for Prehabilitation and other support, to Improving the Cancer Journey (ICJ) routinely, and to Clinical Psychology, spiritual care and counselling as required. Training on aspects of emotional wellbeing is undertaken by Pathway Navigators and Cancer Nurse Specialists for example through Good Conversations and Sage and Thyme training, and case consultation with clinical psychology. Through the recently published Psychological Therapies and Support Framework there will be a continued focus to ensure equitable access to psychological support across Fife and tumour groups, and identify areas for further development

6.4. Identify gaps in medical workforce working with regional partners to develop a regional plan to ensure resilience and equity of care.

6.5. Take forward leadership opportunities across the workforce to highlight opportunities available to cancer workforce colleagues, encouraging new talent to take up leadership roles.

6.6. Make sure all staff have the time to undertake appropriate training and development in order to carry out their role and to equip them for future roles.

6.7. Optimise on education and training from others in the workforce to ensure patients receive the most appropriate care, for example Realistic Medicine, Occupational Medicine and Palliative Care.

An awareness session was carried out by the Realistic Medicine Team which assisted in the development of the Realistic Medicine Plan

Staff have access to the Realistic Medicine Shared Decision module on TURAS (https://learn.nes.nhs.scot/24729) and SWAY.

Tools and education has been provided to the Rapid Cancer Diagnostic Service including personal care and shared decision making.

An online awareness event was undertaken with NHS Fife Cancer Specialist Nurses to increase awareness and provide clarification and tools for embedding Realistic Medicine in practice.

Public Health and the communications team are working on a Communications plan which will include both raising awareness with staff and the public and patients.

Delivered presentations and discussions with HSCP extended leadership team, Project Management Office and there is a date to meet with pharmacy and the Cancer Leadership Team.

Realistic Medicine community meetings have been established to share good practice and understand challenges.

6.8. Take a holistic approach to the management of patients with cancer to include those treating patients who are not in cancer roles, for example inpatients.

6.9. Introduce a cancer awareness programme in teaching of junior doctors to educate and ensure early understanding.

Cancer features in many junior doctor sessions albeit there is no specific cancer education, e.g.

- FY 1: Breaking bad news, specific disease conditions, e.g. common respiratory conditions, palliative care/end of life
- FY 2: Realistic medicine, emergency care, anticipatory care, lifestyle medicine, surgical and haematological emergencies.
- GP core training: people with long term conditions, including cancer and specialty specific education, e.g. dermatology
- Advanced Medicine Core Teaching: undertake oncology training, palliative care and other site specific training which would include cancer conditions
- Grand Rounds can offer specific updates on developments, guidelines and promotions. Our Lead Cancer Nurse actively organises presenters and there is an annual session provided by our CEL30 Lead.

Property and Asset Management

Commitment 7: Ensure our healthcare environments are designed to deliver optimum patient care

To achieve this commitment, we will:

7.1. Review the estate in line with the Board's Property & Asset Management Strategy to accommodate new ways of working and new technologies so that capacity can cope with demand now and in the future.

Year 1 (2022-23)	Establish a working group to develop the concept of a cancer unit in NHS Fife	inks in with Ambulatory work. Identified locations, to progress, C/F take forward 2023-24 - still need to review. Need to understand the Oncology Workforce Review, outcome of IA, etc. Accommodation to repatriate SACT Unit to VHK has been identified; there will be a unit in the tower block which will be a joint unit between haematology, oncology and a bay for other infusions. The business case in currently being written as to what that would look like. There was a discussion about whether haematology and oncology should sit beside other specialities, however, they are currently working through this and how this would sit
Year 2 (2023-24)	Relocate SACT Services to ensure capacity for now and in the future	Planning is underway to ensure SACT services can be relocated when the preferred location becomes available.

7.2. Explore community-based models of care, e.g., community dispensing, supportive therapies and the non-hospital based services, for the palliative phase of illness to ensure services are accessible for all, including people living in the most deprived areas of Fife where incidence and mortality of cancer is higher.

Year 1 (2022-23)	Explore Community and Homecare Dispensing of oral SACT.	A member of staff who is training at present with the prostate oncologists with a view to commencing prescribing clinic for oral prostate SACT.
	Review delivery of Non SACT Interventions.	?

7.3. Develop the case for a Cancer Unit in Fife in line with the developing Population Health and Wellbeing Strategy.

7.4. Assess digital requirements in r elation to development of Hubs for hard-to-reach groups.

Digital Hubs were introduced across NHS Fife however were not successful. The is a requirement to further understand the requirements.

Quality and Performance Improvement

Commitment 8: To make best use of available information sources to assure patients are receiving timely, high quality, effective care.

To achieve this commitment, we will:

8.1. Embed the Effective Cancer Management Framework into the cancer team's workplan, supported by senior management to ensure full adoption.

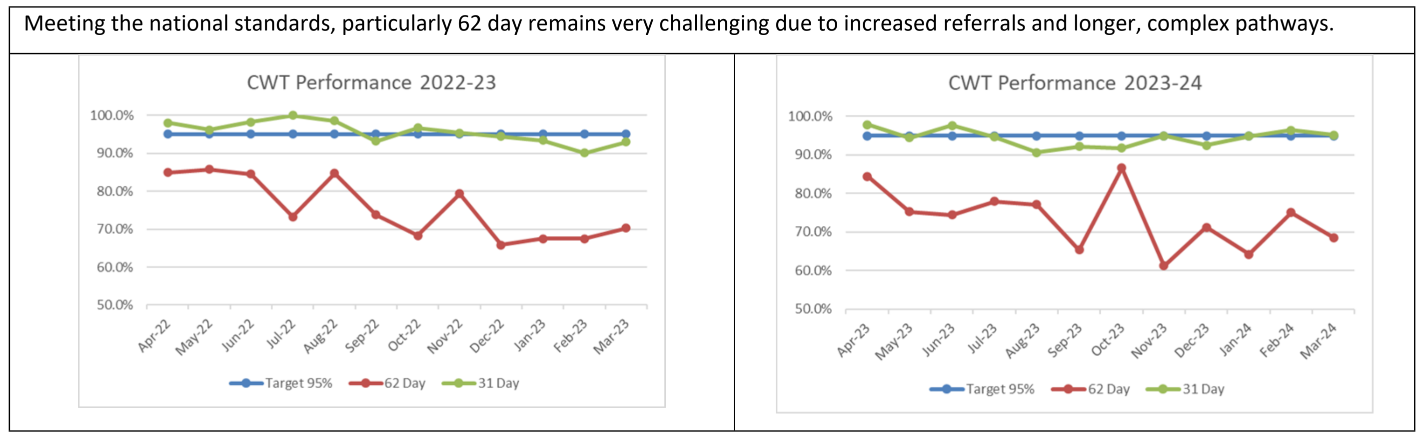
Year 1 (2022-23)	Implement the principles of the effective cancer management framework to manage patients through their pathways.	Action plan completed and agreed. Monthly update provided to SG Frequency changed to quarterly. Update for 2022-23 complete. Identified actions for 2023-24
Year 2 (2023-24)	Deliver agreed 2023-24 actions identified in the Framework for Effective Cancer Management	BAU. Updates against 2023-24 actions are making good progress with 75% (39-52) actions complete or on track.

8.2. Ensure cancer patients continue to be seen and treated as a priority.

Patients referred urgent suspected cancer or diagnosed with cancer continue to be treated as a priority. There is a NHS Fife Standard Operating Procedure in place for the management of patients referred with a suspicion or diagnosed with cancer which incorporates breach avoidance and effective breach analysis.

8.3. View national 62 day and 31 day Cancer Waiting Times targets as a minimum standard.

Meeting the national standards, particularly 62 day remains very challenging due to increased referrals and longer, complex pathways.



8.4. Continue to drive and improve quality performance through robust governance of the Quality Performance Indicators and local use of data to improve service delivery.

Year 2 (2023-24)	Improve quality of cancer staging data	Prostate - there has been an improvement in the recording of Likert and TNM for prostate. This will be reflected in the analysis for the 22-23 cohort at the start of next year. Renal – whilst improvement has been seen TNM recording for renal still needs work. For the 2022 cohort which was reported in September the TNM QPI failed (achieving 77% v the 98% target). Performance has been falling every year since 2019. It depends partly on which radiologist is present, but also whether the cases discussed are clear and obvious cancers (in which case TNM is readily given) or if they are suspicious but not obvious in which case they aren't staged and this chance is missed as they are not then discussed again until after surgery if they have positive histology. c/f 2024-25 Bladder - there has been an improvement in the staging for Bladder cancer although work is still required

8.5. Full engagement with the Cancer Managers' Forum and other national groups to share good practice.

Both the Cancer Transformation Manager and Cancer Audit & Performance Manager attend the quarterly meetings and actively participate.

8.6. Ensure consistent, good quality data collection through formal education for the cancer data collection team and through the formal Quality Assurance programmes.

The Cancer Audit Team undergoes formal training to ensure data capture is accurate and timely. There is intense on the job learning with peer support together with formal guidance and external training such as David O'Halloran Cancer for Non-Clinicians. The team undergoes formal Quality Assurance (QA) on both Cancer Waiting Times and Quality Performance Indicators data. The target is 90% accuracy. The last QA carried out was in 2022 against the Cancer Waiting Time Q3 2021 cohort. The overall accuracy of recording of the data items sampled was 98% with 10 of the 16 data items assess recorded with 100% accuracy. There has been no QAs carried out recently for the QPIs however previous QAs carried out gave an overall accuracy recording of well above the 90% target.

NHS Fife

Meeting: **Clinical Governance Committee**

Meeting date: **1 November 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 via the IPQR relating to Quality and Care, of which, 7 (relating to Adverse Events/SAERS, HSMR & Mental Health Incidents) have no defined trajectory/target.

- Utilising SPC methodology, for all applicable metrics, current position is “within control limits”.
- Targets for Aug-24 were achieved for:
  - Inpatient Falls and those ‘with harm’
  - HAI indicators for ECB and SAB.

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 Aug-24, although there are some measures with a significant time lag and two which are available up to the end of Sep-24.

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.

In relation to Quality & Care section, following review, 'LAER/SAER actions closed on time' measure has been replaced with 'SAERs closed within 90 days'. The SAER median working days to close will be reported going forward.

New measures included this month are within Public Health & Wellbeing section and relate to the uptake of winter Flu and Covid Vaccinations. Measure will be included up to end of Mar-25.

Highlights of September 2024 IPQR

A summary of the status Quality & Care metrics is shown in the table below.

Measure	Current Position	Reporting Period	Planned Trajectory	Target
Adverse Events	44	Aug-24	-	-
SAERs Closed <=90 days	255 (median)	Jul-24	-	-
HSMR	0.96	YE Mar-24	-	-
Falls	6.80	Aug-24	-	6.95
Falls with Harm	1.30	Aug-24	-	1.44
Pressure Ulcers	1.30	Aug-24	-	0.89
Ligature Incidents (MH)	1.34	Aug-24	-	-
Incidents of Restraint (MH)	12.03	Aug-24	-	-
Incidents of Physical Violence (MH)	9.53	Aug-24	-	-
Incidents of Self Harm (MH)	1.67	Aug-24	-	-
SAB (HAI/HCAI)	0.0	Aug-24	-	18.8
C Diff (HAI/HCAI)	13.6	Aug-24	-	6.5
ECB (HAI/HCAI)	10.2	Aug-24	-	33.0
Complaints (S1)	48.7%	Sep-24	-	80%
Complaints (S2)	25.9%	Sep-24	50%	60%

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 September IPQR has been made available for discussion at the meeting on 01 November 2024.

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 17 October 2024

2.4 Recommendation

This paper is provided to Staff Governance Committee members for:

- **Assurance** – This report provides a **"Moderate"** Level of Assurance.
- **Endorse** – Endorse the Quality and Care section of the IPQR.

3 List of appendices

The following appendices are included with this report:

- IPQR Position at September 2024

Report Contact
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Planning and Performance Manager
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Fife Integrated Performance & Quality Report (IPQR)

Position (where applicable) at September 2024

Produced in October 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. 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.

   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.

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

MARGO MCGURK
Director of Finance & Strategy
14 October 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	5	3	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	6	1	-	-	◀▶	Moderate
Total	20	15	5	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 Decreased
- ◀▶ No Change
- ▼ Deteriorated - Risk Increased

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.

There have been two new risks added and one removed from the Corporate Risk register as below:

Risk 20 - New Corporate Risk - Capital Funding - Service Sustainability

A new risk was supported by EDG and aligned to FP&R committee.

Reduced capital funding will affect our ability (scale and pace) to deliver against the priorities set out in our Population Health and Wellbeing Strategy. It may also lead to a deterioration of our asset base including our built estate, digital infrastructure, and medical equipment. There will be less opportunity to undertake change projects/programmes.

Risk 21 - New Risk Pandemic Risk

A new risk was supported by EDG and aligned to the PHWC.

A novel pandemic with widely disseminated transmission and significant morbidity and mortality may cause significant harm to those infected and cause widespread disruption to healthcare, supply chains, and social functioning.

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.

B. Indicator Summary

Quality & Care

Indicator	Current	Previous	Change	Indicator	Current	Previous	Change	Indicator	Current	Previous	Change
SAER Median days to close	255		—	Inpatient Falls	6.80	6.80	◆	Pressure Ulcers	1.30	1.57	▲
Ligature Incidents (Mental Health)	1.34	0.17	▼	Incidents of Restraint (Mental Health)	12.03	7.93	▼	Incidents of Physical Violence (Mental Health)	9.53	7.93	▼
Incidents of Self Harm (Mental Health)	1.67	1.03	▼	SAB HAI	0.0	6.8	▲	C Diff HAI	13.6	17.1	▲
ECB HAI	10.2	6.8	◆	S1 Complaints Closed in Month on Time	48.7%	50.0%	◆	S2 Complaints Closed in Month on Time	25.9%	16.7%	▲

Operational Performance

Indicator	Measure	Current	Previous	Change	Indicator	Measure	Current	Previous	Change	Indicator	Measure	Current	Previous	Change
Emergency Access	A&E	75.4%	73.8%	▲	Delayed Discharges (Standard)	Acute/Comm	52.3	51.1	◆	Cancer	31-day DTT	94.2%	98.2%	▼
Emergency Access	ED	67.6%	65.4%	▲	Delayed Discharges (Standard)	MH/LD	12.1	9.3	▼	Cancer	62-Day RTT	67.5%	78.2%	▼
Patient TTG	% <=12weeks	49.5%	49.4%	◆	New Outpatients	% <=12weeks	40.1%	41.3%	▼	Diagnostics	% <=6weeks	71.0%	63.2%	▲
Patient TTG	>52 weeks	712	659	▼	New Outpatients	>52 weeks	5033	4891	▼	Diagnostics	>26 weeks	58	48	◆

Finance

Indicator	Current	Change	Indicator	Current	Change
Revenue Resource Limit Performance	(£23.555m)		Capital Resource Limit Performance	£1.990m	

Workforce

Indicator	Current	Previous	Change	Indicator	Current	Previous	Change	Indicator	Measure	Current	Previous	Change
Sickness Absence	6.51%	7.47%	▲	Personal Development Plan & Review	42.9%	44.5%	▼	Vacancies	Medical & Dental	2.8%	6.2%	▲
								Vacancies	Nursing & Midwifery	3.5%	3.8%	◆
								Vacancies	AHPs	5.0%	3.7%	▼

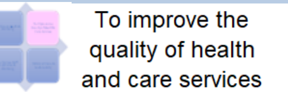
Public Health & Wellbeing

Indicator	Current	Previous	Change	Indicator	Current	Previous	Change	Indicator	Current	Previous	Change
Smoking Cessation – 40% Most Deprived	285	255	—	Alcohol Brief Interventions	103%	96%	—	Drugs & Alcohol	94.5%	93.1%	◆
CAMHS	94.3%	83.5%	▲	Psychological Therapies	72.8%	69.8%	▲	Mental Health Readmissions within 28 days	5.6%	5.9%	◆
Breast Screening	73.4%		—	Bowel Screening	66.2%		—	AAA Screening	87.3%	86.8%	▲
Childhood Immunisation – 6-in-1 @ 12 months	94.5%	95.1%	▼	Infant Feeding	36.4%	29.4%	▲	Winter Vaccination – Influenza	40.6%		—
Childhood Immunisation – MMR2 @ 5 years	85.7%	85.7%	◆	Child Development	19.4%	18.5%	▲	Winter Vaccination – Covid	39.2%		—

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	**44**	Month	Aug-24			○	◆	▼		●	
SAER - Median days to close	**255**	Quarter	Jul-24			●	—	—		●	
HSMR	**0.96**	Year to	Mar-24			○	—	—		●	
Inpatient Falls	**6.80**	Month	Aug-24		6.95	○	◆	◆		●	
Inpatient Falls with Harm	**1.30**	Month	Aug-24		1.44	○	◆	◆		●	
Pressure Ulcers	**1.30**	Month	Aug-24		0.89	○	▲	▼		●	
Ligature Incidents (Mental Health)	**1.34**	Month	Aug-24			○	▼	◆		●	
Incidents of Restraint (Mental Health)	**12.03**	Month	Aug-24			○	▼	▼		●	
Incidents of Physical Violence (Mental Health)	**9.53**	Month	Aug-24			○	▼	◆		●	
Incidents of Self Harm (Mental Health)	**1.67**	Month	Aug-24			○	▼	▼		●	
SAB - Healthcare associated infection	**0.0**	Month	Aug-24		18.8	○	▲	▲		●	YE Jun-24
C Diff - Healthcare associated infection	**13.6**	Month	Aug-24		6.5	○	▲	▼		●	YE Jun-24
ECB - Healthcare associated infection	**10.2**	Month	Aug-24		33.0	○	◆	▲		●	YE Jun-24
S1 Complaints Closed in Month on Time	**48.7%**	Month	Sep-24		80%	○	◆	◆		●	2022/23
S2 Complaints Closed in Month on Time	**25.9%**	Month	Sep-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

SAERs

Reviewing, Learning and Improving from Adverse Events

SAERs to be closed within 90 working days of commissioned date

Median 255 days

C1. Quality & Care

Data Analysis

There were 44 **Major/Extreme adverse events** reported in Aug-24 out of a total of 1,447 incidents.

69% 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 (262) followed by 'Cardiac Arrest' (69 incidents), and then 'Other Clinical Events' (46 incidents).

There were 6 **SAERs** commissioned in Aug-24 and 31 (4 on average a month) in 2024 so far. In comparison, there were 5 SAERs commissioned on average per month in 2023, 64 in total.

There were 52 SAERs closed in the 12 months to Jul-24 with median working days to close of 221 days. For the latest 3 months ending Jul-24, there was 13 closed with median days to close of 255 days, this compares to 18 closed and 203 days for 3 months ending Oct-23.

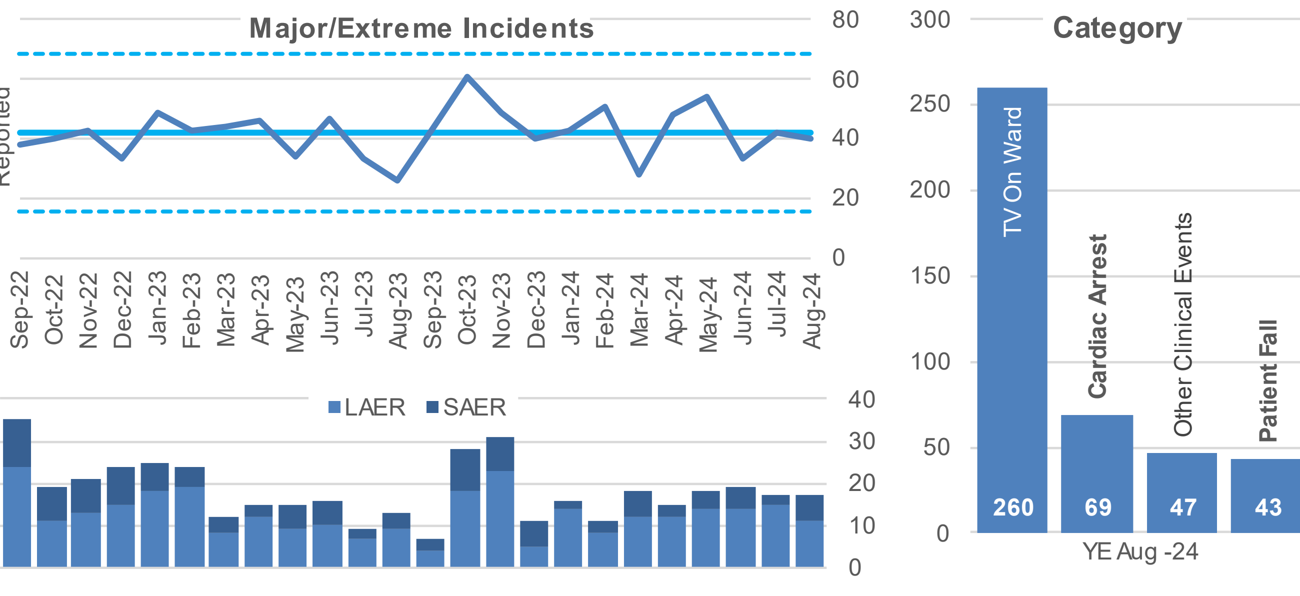
Achievements & Challenges

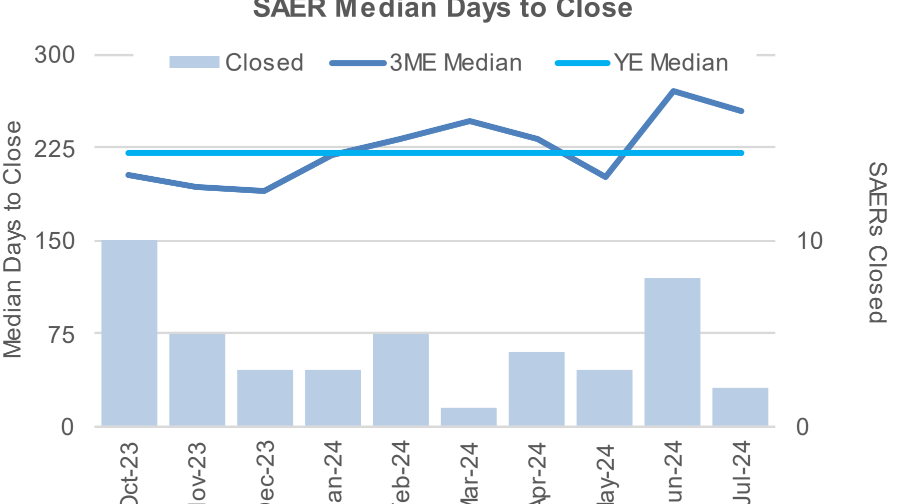
The highest reported subcategory reported as within the 'Other Clinical Events' category is unexpected death, which accounts for 20 of the 46 events. All of which are undergoing, or have completed, a SAER or speciality specific review (i.e. drug and alcohol death cluster review).

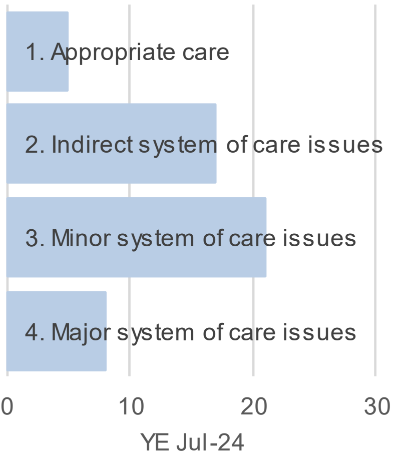
With a focus on preventability and improvement, SAERs with a review outcome 4 (Major System of Care Issues) require the improvement plan to be submitted to the SAER executive panel for oversight and monitoring. As part of the adverse events improvement plan this change to process became effective from 1st August 2024.

Of the 9 SAERS that were approved with a review outcome 4, four have had all assigned actions closed with three having no improvement plans or actions uploaded to Datix - a review of the status of these is underway.

The delay in completion of SAERs within 90 days is multi-factorial with some of these factors being un-modifiable i.e. patient complexity, delay in postmortem result. Similar challenges are experienced by every Board in Scotland and NHS Fife are not an outlier in this respect. The adverse events improvement plan identifies a number of process changes to improvement on timely and quality completion of reviews. One of the priorities of the improvement plan is the refreshed trigger list, to align with the national framework.







Inpatient Falls

Reduce Inpatient Falls rate by 15% to 6.95 per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	6.80	Trajectory achieved as of Aug-24
Reduce Inpatient Falls with Harm rate by 10% to 1.44 per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	1.30	Trajectory achieved as of Aug-24

C1. Quality & Care

Data Analysis

In Aug-24, there were 194 inpatient Falls in total: 4 more than month prior, but 13 fewer than the 24-month average. This equates to a rate of 6.80 falls per 1,000 Occupied Bed Days (OBD): this was the same rate as month previous. Performance has therefore achieved the target of < 6.95 for two consecutive months.

Average rate was 7.30 for YE Aug-24 compared to 7.43 for YE Aug-23.

The number of inpatient Falls 'with Harm' was 37 in Aug-24, just 1 less than month prior but 8 fewer than the 24-month average. This equates to a rate of 1.30 falls per 1,000 OBD: this is an improvement on month previous. Performance has therefore achieved the target of < 1.44 for two consecutive months.

Average total rate was 1.59 for YE Aug-24 compared to 1.63 for YE Aug-23.

Acute Services have seen an increase in All Falls rate over the past two months (13 more falls, rate of 7.54); whereas HSCP saw a decrease in All Falls rate (22 fewer falls, rate of 6.10).

For QE Aug-24, Falls classified as 'Major/Extreme Harm' accounted for 1.7% of Falls with Harm, compared to 6.7% for QE May-24.

Achievements & Challenges

HSCP Update

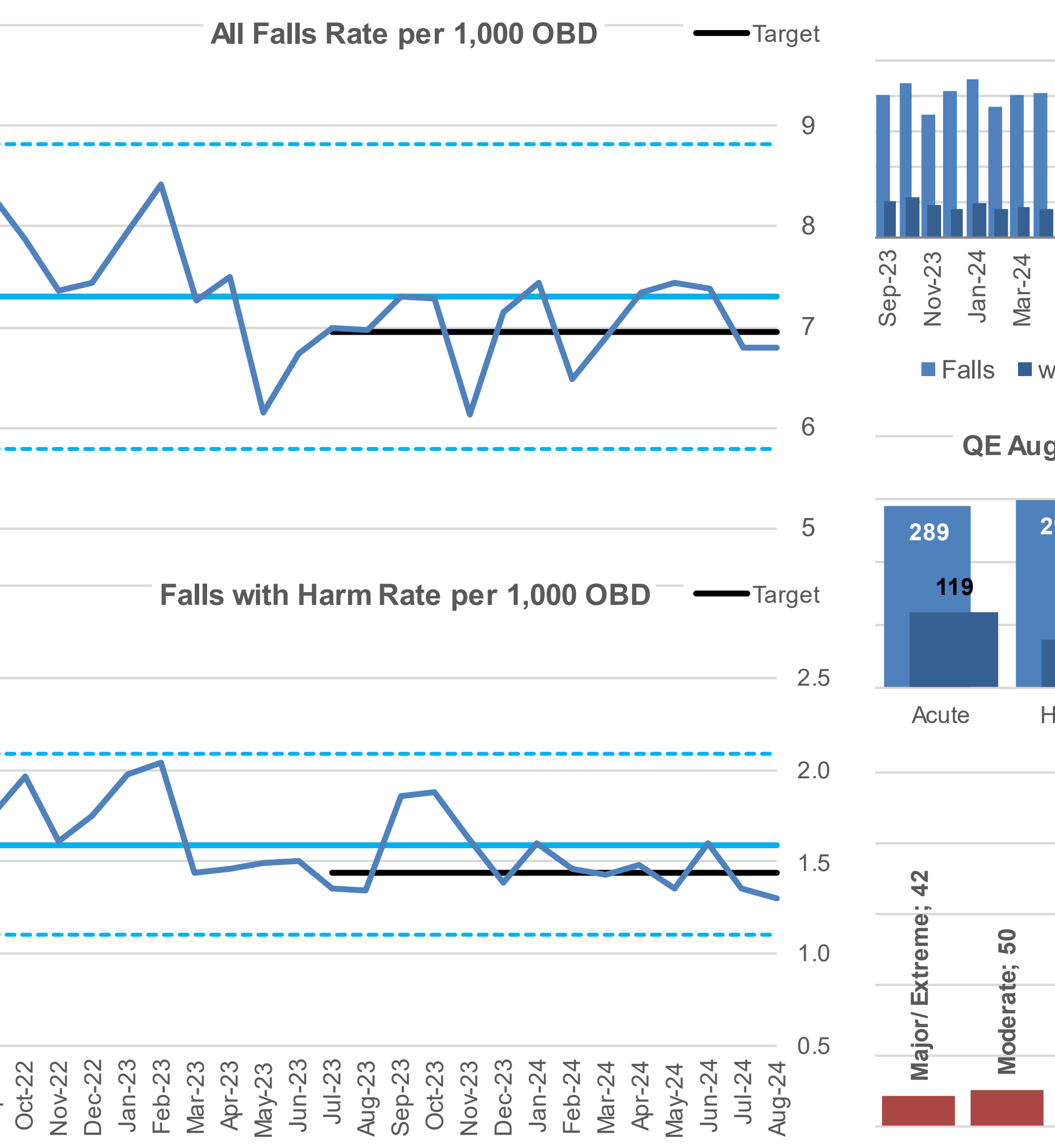
- Sharp increases in falls are investigated with the ward areas to identify immediate actions for change/improvement.
- Falls data is discussed at the bi-weekly QMASH meetings and bi-monthly data is presented at QMAG meetings.
- In regard to Lateral lifters, it was noted that the lifter at Stratheden Hospital, based within Elmview ward, will potentially be out of commission due to issues transporting between wards, particularly at night. There are ongoing discussions with Health & Safety Advisors regarding this matter.

Acute Update

- Falls Link Practitioner event held on the 25th September 2024 (PM) was well attended with positive feedback.
- Wards 43 & 54 are undertaking QI projects related to decaffeinated drinks and the impact on reducing falls.

Fife Wide Update

- A new proposed trigger list for Falls has been agreed and will focus on the outcome for the patient and not on the area of the body which has been injured. This has to be discussed at CGOG.



Pressure Ulcers

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

1.30

12 pressure ulcers to achieve target

C1. Quality & Care

Data Analysis

The total number of pressure ulcers in Aug-24 was 37, an improvement on the month previous (44). This equates to a rate of 1.30 per 1,000 Occupied Bed Days (OBD). Performance continues to remain 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 Aug-24 was 32, 1 less than in Jul-24 (rate decreased from 2.48 to 2.32). For YE Aug-24, the average number of pressure ulcers was 29 (rate 2.14); whilst the average number in YE Aug-23 was 24 (rate 1.82).

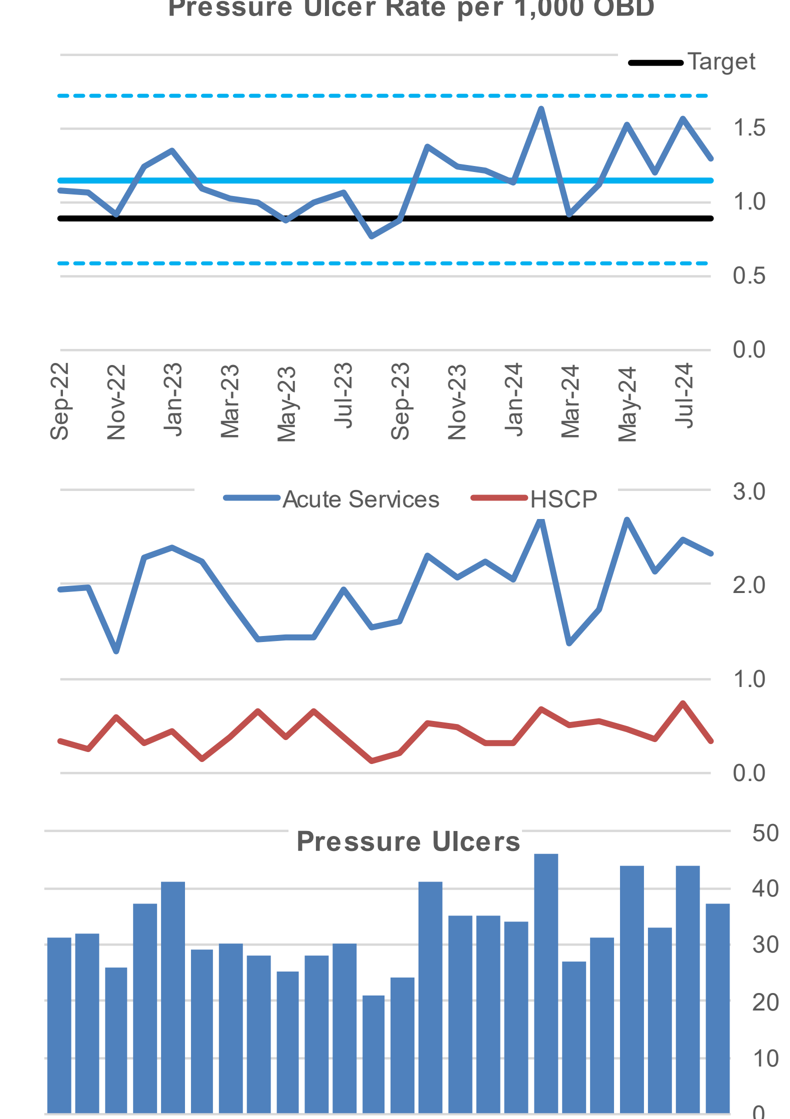
In HSCP, the average number of pressure ulcers for YE Aug-24 was 7 (rate 0.46); whilst the average number in YE Aug-23 was 6 (rate 0.39).

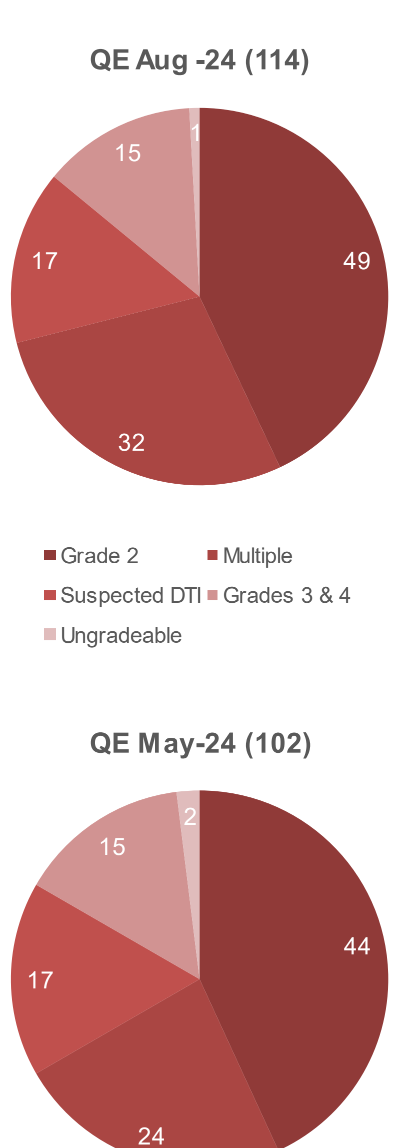
Most pressure ulcers continue to be in Acute Services with 93 recorded in QE Aug-24; there were 21 recording in HSCP in the same period. Of all Pressure Ulcers recorded in QE Aug-24, Grade 2 accounted for 43% of the total; with Grades 3 & 4 accounting for 15%.

Achievements & Challenges

Within the Fife HSCP, numerous education opportunities have been delivered to care homes, community inpatients and specialist nursing teams. The Community Tissue Viability Link Practitioners' Network has been re-established.

Whilst the incidents within the HSCP compared to August last year have increased by 1, the incidence compared to July 24 has reduced . We have now established our Tissue Viability Improvement Group and this group has wide representation from both HSCP and Acute Services: there have been 3 SLWGs set up focusing on the 7 standards within the change package and again this is a joint approach with our colleagues from acute care. In Acute Services we completed a system-wide review of all pressure damage incidents and identified key areas for improvement: including timely bedside assessments; accurate documentation; and better communication with patients and families. To address these issues, actions have been initiated: such as enhanced training; random audits; and strengthening collaboration between Allied Health Professionals (AHPs) and nursing staff. A SLWG will focus on improving reporting and data capture, while nursing documentation processes are being revised. These efforts, alongside interdisciplinary teamwork, aim to reduce pressure damage incidents and enhance quality.





Mental Health Quality Indicators

Indicator	Value
Reduce **Ligature** Incidents (rate per 1,000 Occupied Bed Days)	1.34
Reduce incidents of **Self Harm** (rate per 1,000 Occupied Bed Days)	1.67
Reduce Incidents of **Restraint** (rate per 1,000 Occupied Bed Days)	12.03
Reduce Incidents of **Physical Violence** (rate per 1,000 Occupied Bed Days)	9.53

C1. Quality & Care

Data Analysis

There was 266 incidents reported in relation to Mental Health wards in Aug-24, an increase from 239 previous month and remains above 24-month average of 238 per month. There were eight Ligature incidents reported in Aug-24, highest since 20 reported in Feb-24, with rate above 24-month average after 5-months below. The number of incidents of self-harm was 10 in Aug-24, highest since Feb-24, rate above 24-month average after 5-months below.

Rate of Restraint has increased to 12.03 per 1,000 Occupied Bed Days in Aug-24, was below 24-month average in Jul-24 but above in every other month in 2024 apart from Jan-24. 57 incidents of Physical Violence were reported in Aug-24, an increase from 46 month prior, equating to a rate of 9.53 per 1,000 Occupied Bed Days. Rate was below the 24-month average twice so far in 2024, Jan-24 and Jul-24.

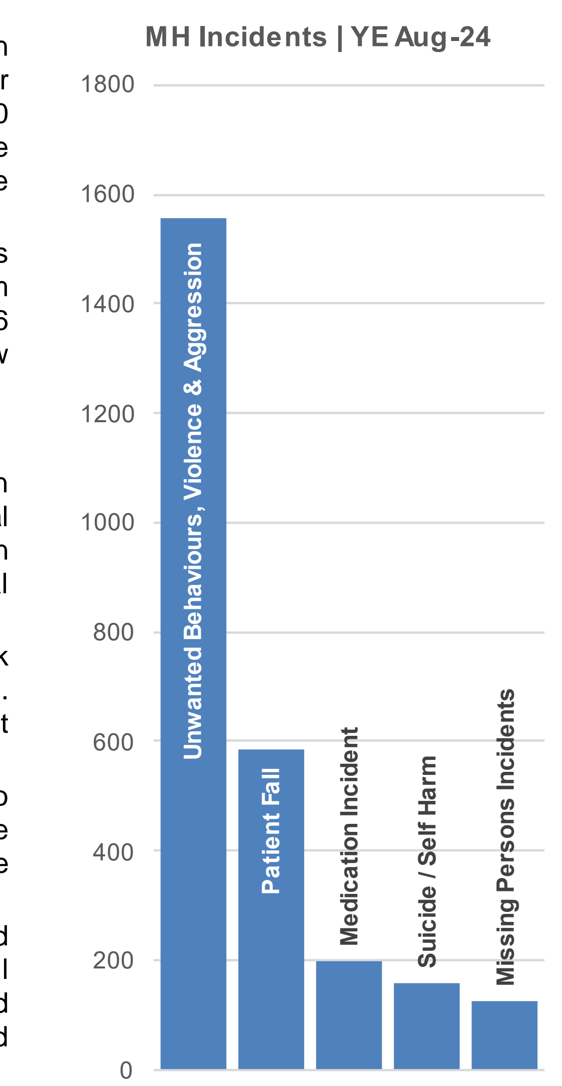
Achievements & Challenges

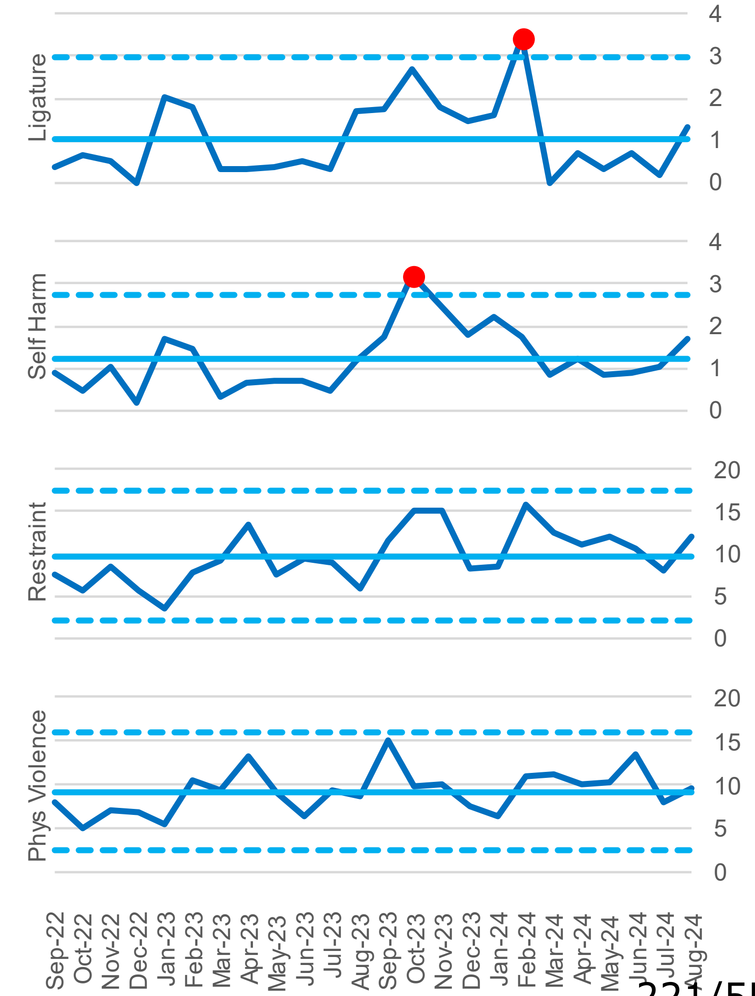
Significant work now restarted with W3 QMH and decant of wards to provide an improved anti-ligature environment. Design of ward is being developed with clinical input and reporting to the ligature board. Whilst this work is ongoing all staff within inpatient areas remain vigilant for any ligature concerns and managing individual patients based on need and risk assessments.

The ligature operational group is up to date with all H&S Environmental Ligature Risk Assessments and mitigation plans and any appropriate escalations to ligature board. The Ligature policy for NHS Fife and Fife HSCP has been completed and approved at Fife Policy and Procedure group.

Incidents of self-harm have slightly increased but overall remain low with no concentrated work on reducing self-harm. The risk of self-harm continues to be managed with all staff being vigilant and aware of individual need, risk and care planning.

Reducing Restrictive Practice Group (RRPG) has moved to a new focus around seclusion, Scottish Patient Safety Programme and observation and intervention This will involve work on Leadership and Culture, Safe Clinical Care, Safe Communications and Person-Centred care. Subgroups for each of these areas have been developed and looking to identify key strategies to progress on these workstreams.





Healthcare Associated Infections

CDI: Achieve and maintain rate of 6.5 per 100,000 Total Occupied Bed Days	13.6	3 ↓	infections to achieve target
ECB: Achieve and maintain rate of 33.0 per 100,000 Total Occupied Bed Days	10.2		Target achieved
SAB: Achieve and maintain rate of 18.8 per 100,000 Total Occupied Bed Days	0		Target achieved

C1. Quality & Care

The **CDI HAI/HCAI** rate decreased to 13.6 in Aug-24. The cumulative total of HCAI infections for past 12 months (n=25) is lower than the same period previous year (n=39), The number of recurring infections has also decreased.

80% of the HCAI cases YE Aug 24, had taken antibiotics in the 12 weeks prior to CDI infection and 56% cases were on a PPI. IPCT continue to highlight rates and risk factors of cases to relevant personnel.

The **ECB HAI/HCAI** rate increased to 10.2 in Aug-24 with number of healthcare infections increasing from 9 in Jul-24 to 11 in Aug-24. The cumulative number of HCAI infections over last 12 months (n=142) is higher than the same period previous year (n=112). However, there was a decrease in the number of CAUTI related ECBs. Urinary Catheter related infections have been responsible for 27 of the 142 infections in the last year (19%) the 'Not Known' category accounts for 22.5% of reported HCAI infections.

However, the number of CAUTI related ECBs has reduced during this time-period. Hepatobiliary, renal tract and medical device other than VAD, are the most common sources of infection identified amongst YE Aug 24 cases.

The monthly CAUTI related ECB Complex Care Review (CCR) meetings continue to take place to identify any learning points which can influence future practice. The Urinary Catheter Improvement Group (UCIG) last met in Aug 24 . The aim of the group is to establish catheter improvement work in Fife, to reduce the number of CAUTI related infections. The learning from the groups are fed into the Infection Control Committee.

The eCatheter bundle group met in August to finalise the pathways for catheter insertion and maintenance systems for both the acute and HSCP.

The **SAB HAI/HCAI** rate was 0 in Aug-24, with the rate falling to its lowest level in the last 24 months. Of the 43 HCAI cases reported in the last 12 months, 14 have been categorised as 'Vascular Access Devices (VAD)' with 9 'Other' or 'Not Known' and 3 as 'Device Other Than VAD'. The cumulative number of HCAI cases in last 12 months (n=43) was lower than during the same timeframe the previous year (n=51).

There has been an increase in the number of PVC related SABs this year. A CCR is carried out on each case to ascertain any practice issues which may require improvement and possible future changes to practice.

Complaints

At least 80% of Stage 1 complaints will be completed within 5 working days by March 2025

48.7%

12 closed on time to achieve target

At least 60% of Stage 2 complaints will be completed within 20 working days by March 2025

25.9%

7 closed on time to achieve trajectory

C1. Quality & Care

Data Analysis

There were 37 Stage 1 complaints received in Sep-24, with 39 closed. Of those closed 19 (48.7%) were within timescales. 51.5% of 33 complaints that were due in the month, were closed on time.

There were 33 Stage 2 complaints received in Sep-24, all acknowledged within timescales, with 27 closed. 25.7% of 35 complaints that were due in the month, were closed on time.

There are currently 3 S2 complaints over 100 days: there is an outlier at 263, which involved a SAER and is currently being drafted by the PET. There are 18 S2 complaints between 50 and 100 days, with 16 (89%) awaiting action from the Service, 2 (11%) with PET, one awaiting action and one ready to draft. At the end of Sep-24, the average number of days to close S2 complaints was 44 days, the lowest it has been in 24/25.
The average response time for S2 Complaint responses has reduced to 44 days in Sep-24, the lowest this year. Although not meeting the 60% target compliance for Stage 2s closed within 20 working days, there has been a shift in the data (seven points above the median) since Feb-24 which is indicative of improvement.

Achievements & Challenges

Continued focus on clearing backlogs across all complaint work streams: data shows that older cases and volumes with a positive outcome are significantly reduced. Services reminded of need for local resolution of S1 complaints within 5-working-days timeframe and with a direct dialogue between the Services and the Complainant. This proactive approach to complaint resolution helps achieve the 80% target. Terminology has been changed on Datix to reflect focus on 'Verbal Resolution' and away from 'Awaiting Statements'. Continued focus on reducing open S1, concerns, and enquiries. At the start of Q2, there were 35 open S1, 61 concerns, and 35 enquiries. At the start of Q3, there has been a significant reduction in all three, with 16 open S1, 24 concerns and 8 enquiries. This is an improvement reduction of 36% for open S1, 61% for concerns and 77% for enquiries.
Weekly meetings with PET and Services have been paused: replaced by a greater focus on daily reviews of S1 and S2 complaints. Delays are escalated to the Head of PET and internally within the services. Discussions are ongoing with Services to streamline the complaint handling processes and to manage and progress complaints more efficiently.
The Complaints Dashboard provides a level of detail that clarifies where each complaint is in the Complaint Handling Procedure. Additional fields added to highlight where prompt action required.
PET are collaborating with the Datix team to implement a feature that calculates the number of days taken for PET to draft a response. Currently, this calculation is done manually, which is inefficient and time-consuming.
A new 'factual account template' has been created to replace the 'statement memo'. The Service can ensure the response fully covers the complaint points and is well written. PET can complete the quality check and provide feedback to the Service or the staff member if required. Initially tested within the Medical Directorate, it received positive feedback and has now been rolled out to all. The new factual account template aims to improve the quality of the complaint response and support the completion more promptly.
PET conducted complaints training within several Services in Sep-24. They also attended the Newly Qualified Practitioners Event to showcase the role of the PET within the Organisation, and to provide an overview of the complaints process, and communicate the support available from the PET for new employees.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**HAIRT 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 total number of CDI cases (September 2023 to August 2024) from same time period previous year.
- The total of community acquired (CAI) CDIs during January - August 2024 was higher than during the same time period the previous 2 years

***Staphylococcus aureus* Bacteraemia (SABs)**:
- A lower rate of SABs was recorded for year ending August 2024 from same time period previous year.

***Escherichia coli* Bacteraemias (ECBs)**:
- Healthcare associated ECBs remain a challenge, with higher infection rates for year ending August 2024.
- A lower rate of CAUTI recorded January – August 2024, than the same time period the previous year.

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

Hospital Inspection Team
- There have been no new inspections during this reporting period (July – August 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 (July and August 2024)
- Norovirus**:** 3 new ward or bay closures due to a Norovirus or suspected Norovirus
- Seasonal Influenza: no new closures due to confirmed Influenza outbreaks
- COVID-19: 5 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 October 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 October 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=84), during the time-period September 2023 to August 2024, was lower than during the same timeframe the previous year, when there were 93 HCAI SABs.
- There were 5 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 September 2023 -end of August 2024, there was a reduction in the total number of CDI cases (n=48), when compared to the same timeframe the previous year (n=50). This improvement is also reflected in the number of HCAI cases (year ending August 2024, n=25 cases, compared to year ending August 2023, n= 39 cases).
- The total of Community acquired (CAI) CDIs during January - August 2024 (n=18) 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 total number of ECBs, when comparing year ending August 2024 (n=271 cases) to year ending August 2023 (n=243).
- There was also an increase seen in the number of HCAIs during the same time-period.
- There has been a reduction in the number of CAUTI related ECBs during the same time period.
- During Q1 2024 (January to March), NHS Fife was below the national rate for community acquired infection.

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 (July - August 2024)

Norovirus

- There have been 3 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

- 5 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 (July – August 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 October 2024 and Executive Director Group on 17 October 2024.

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a **"Moderate"** Level of Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Healthcare Associated Infection Report

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Infection Prevention
and Control Team

HAIRT Report

HAIRT Report for Infection Prevention & Control Committee on 1st October 2024

(Validated Data up to end of August 2024)

October 2024

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Published Month Year

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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=84), during the time-period September 2023 to August 2024, was lower than during the same timeframe the previous year, when there were 93 SABs. This improvement is also reflected in the number of HCAI when comparing year end August 2024 (n=43) to year end August 2023 (n=51).

Clostridioides difficile **Infection (CDI)**

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

The total number of CDIs (n=48), during the time-period September 2023 to August 2024, was lower than during the same timeframe the previous year, when there were 50 CDIs. This improvement is also reflected in the number of HCAI cases when comparing year ending August 2024, (n=25) to year ending August 23 (n= 39).

Escherichia coli **bacteraemia (ECB)**

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

There has been a reduction in the number of CAUTI related ECBs Jan-Aug 24 (n=15) in comparison to during the same time period the previous 2 years (Jan-Aug 23, n=17 and Jan-Aug 22, n=20).

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 5 PVC related SABs so far this year (Jan-Aug 2024). A complex Care Review is done on each case. Previously 367 had passed without a PVC related SAB.
- There have been no dialysis line related SABs since the previous report. So far this year (Jan-Aug) there have been 4 dialysis line related cases.

- There have been 7 PWID related SABs Jan-Aug 24. This is slightly higher than during the same time period the previous 2 years (Jan-Aug 23, n=6 and Jan-Aug 22, n=6)

CDI

The total of Community acquired (CAI) CDIs during Jan-Aug 2024 (n=18) was higher than during the same time period the previous 2 years (Jan-Aug 2023, n=9 and Jan-Aug 2022, n=8). PPI was the most common risk factor seen amongst the CAI cases (61% of cases), followed by antibiotic use in the 12 weeks prior to CDI infection (56% of cases). For noting, 33% cases had PPI and previous antibiotic in the preceding 12 weeks, as a factor.

ECBs

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

There has been an increase in the total number of ECBs, when comparing year ending Aug 2023 (n=243 cases) to year ending June 2024 (n=271). This increase is also reflected in the number of HCAI cases during the 2 time periods (year ending Aug 2023, n=112, compared to year ending Aug 2024, n=142).

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

<table>
<tr><th colspan="5">Staphylococcus aureus Bacteraemias (SABs)</th></tr>
<tr><th colspan="5">Local Data: Q2 2024 (Apr-Jun)
(Q2 2024 National comparison awaited)</th></tr>
<tr><td rowspan="2">In Q2 2024 NHS Fife had:</td><td rowspan="2">27 SABs</td><td>18 HCAI/HAI</td><td rowspan="2">This is UP from:</td><td rowspan="2">23 Cases in Q1 2024</td></tr>
<tr><td>9 CAI</td></tr>
</table>

<table>
<tr><th colspan="4">Q1 2024 (Jan-Mar) - ARHAI Validated data with commentary</th></tr>
<tr><th colspan="2">Healthcare associated SABs</th><th colspan="2">Community associated SABs infection</th></tr>
<tr><td>HCAI SAB rate: 13.2</td><td rowspan="2">Per 100,000 bed days</td><td>CAI SABs rate: 14.1</td><td rowspan="2">Per 100,000 Pop</td></tr>
<tr><td>No of HCAI SABs: 12</td><td>No of CAI SABs: 13</td></tr>
<tr><td colspan="2">This is BELOW National rate of 17.0</td><td colspan="2">This is ABOVE National rate of 10.9</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="4">NHS Fife was not an outlier for SABs in Q1 2024.</td></tr>
</table>

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.
- 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 August 2024. The cases will undergo a Complex Care Review, to ascertain learning

As of **01/09/2024** the number of days since the last confirmed SAB is as follows:	
CVC SABs	97 Days
PWID (IVDU)	24 Days
Renal Services Dialysis Line SABs	82 Days
Acute services PVC (Peripheral venous cannula) SABs	61 Days

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

2.2 Current SAB Initiatives

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

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

2.3 National MRSA & CPE screening programme

MRSA

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

NHS Fife achieved **90%** compliance with the **MRSA** CRA in Q2 2024 (Apr-Jun)

This was **BELOW** Q1 2024 (95%), and **ON** the compliance target of 90%.

It was ABOVE the national rate of 80.5% 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%	80.5%

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%)

It was **BELOW** the national rate of 81.3% 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%	81.3%

The CPE CRA 20% non-compliance was an unusual occurrence, therefore, the 8 cases (accounting for the 20% compliance failure) were looked at more closely to assess the reason for non-compliance. In general, the CPE CRA was being completed in paper form on admission to hospital. However, there appears to be a delay in the information being added to the Patient Trak system. This looks like a system failure as opposed to a clinical failure. IPCT will continue to monitor.

3. Clostridioides difficile Infection (CDI)

3.1 Trends

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

Healthcare associated CDIs		**Community associated CDIs infection**	
HCAI CDI rate: **4.4**	Per 100,000 bed days	CAI CDIs rate: **4.3**	Per 100,000 Pop
No of HCAI CDIs: 4		No of CAI CDIs: 4	
This is **BELOW** National rate of 12.6		This is **BELOW** National rate of 7.0	
NHS Fife was not an outlier for CDIs in Q1 2024.			

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	19.5%	**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%**	* Locally calculated data- TBC by ARHAI when Q2 2024 data published on Discovery
2020 TOTAL	16.4 %	**27.5 %**	
2019 TOTAL	16.1 %	**24.5 %**	
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	21.5%	**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 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 **8th August 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-Aug 2024, there were 15 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.

The eCatheter bundle group met on 20th August to finalise the pathways for the catheter insertion & maintenance systems for both the acute & HSCP. These updated bundles have been forwarded onto the D&I team and a response is awaited to progress this action.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections and to minimise 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	95.2	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	96.4	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.

July – end of August 2024

Norovirus

There have been 3 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

There has been 5 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
Glenrothes	Ward 1	July 2024	0	3	1
Cameron	Balgonie	July 2024	0	2	0
QMH	Ward	Aug 2024	0	11	2
Cameron	Balgonie	Aug 2024	0	5	1
VHK	Ward 41	Aug 2024	0	2	0

8. Surgical Site Infection Surveillance Programme

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

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

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been 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-Aug), compared to Jan-Aug 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.
- **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 carry out MDRO screening compliance and, highlight and support areas of non-compliance.
- Communication channels between IPCT and Addictions Service remain in place, with the offer of further support, if required.
- **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
Jul-24	2	5	7	5	3	8	9	10	19
Aug-24	0	1	1	4	0	4	11	16	27

Cleaning Compliance (%) TOTAL FIFE												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	Jul 24	Aug 24
Overall	95.7	96.0	96.2	95.8	95.8	95.9	96.3	96.5	96.3	96.1	96.0	95.6

Estates Monitoring Compliance (%) TOTAL FIFE												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Overall	96.2	95.7	96.2	95.9	96.8	96.6	96.3	96.9	96.9	96.7	96.4	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
Jul-24	2	2	1
Aug-24	0	1	3

Cleaning Compliance (%) Victoria Hospital												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Overall	95.8	96.4	96.0	95.9	95.1	94.9	95.9	96.2	95.3	95.8	95.1	95.0

Estates Monitoring Compliance (%) Victoria Hospital												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Overall	97.6	97.1	97.3	96.5	97.7	97.3	97.2	97.6	97.6	97.3	97.2	97.1

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
Jul-24	0	0	1
Aug-24	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Overall	96.4	96.8	97.4	96.6	97.0	97.5	96.7	97.7	97.4	96.5	97.0	96.4

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Overall	94.4	95.5	95.3	96.4	96.2	95.6	95.7	95.6	95.9	95.9	95.7	96.3

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
Jul-24	0	1	0
Aug-24	0	2	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
Jul-24	0	5	2	3	7	10
Aug-24	0	1	1	0	8	16

Appendix 1 References and Links

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

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

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

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

Hospital Acquired Infection (HAI):

Positive Blood culture obtained from patient who has been

-Hospitalised for >48 hours

If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission

OR

-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained

OR

-A patient receives regular haemodialysis as an outpatient

Community Infection

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

Not known:

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

Healthcare Associated Infection (HCAI):-

Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:

-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.

OR

-Resides in a Nursing home, long term facility or residential home

OR

-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.

OR

-Underwent venepuncture in the 30 days before +ve BC

OR

-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC

OR

-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion

OR

-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

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

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

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

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

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

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Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Rapid Cancer Diagnostics Services Update**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Murdina MacDonald, Lead Cancer Nurse**
	Mr Neil Cruickshank, Consultant Colorectal Surgeon

Executive Summary

- This report aims to inform stakeholders of the key findings from the University of Strathclyde evaluation of the NHS Scotland Rapid Cancer Diagnosis Service (RCDS) pilots.

- The aim of the RCDS service was to develop a person-centred diagnostic pathway and provide primary care with a new route through which to refer **patients with non-specific symptoms**, such as unexplained weight loss, pain or fatigue that may be suspicious of cancer. The pilot programme was planned to run from June 2021- March 2024.

- Roll out of the RCDS model is planned for all health boards by 2025-6 and is a key part of the NHS Scotland Cancer strategy (2023).

- Optimal Components of RCDS were found to be:
  - Vetting and triage by RCDS team
  - Personalised single point of contact for each patient
  - Enhanced Patient experience
  - Coordination of testing (low Did Not Attend (DNA) rate)
  - Diagnostic decision making by RCDS team and multi-disciplinary team
  - Appropriate onward referral by RCDS team

- Economic Evaluation for NHS Fife was an additional cost of £135 per patient but a reduction in pathway of 75 days (compared to standard urgent non urgent suspicion of cancer referral).

- Overall, the economic evaluation of NHS Fife's RCDS was extremely favourable in term of its Institute of Clinical and Economic Review (ICER) reduction in the pathway and cost per patient. To create a sustainable model additional staffing was required however this additional capacity has been utilised cost effectively in expanding the service to include upper gastro-intestinal and hepatobiliary referrals.

- Funding has been approved for the Rapid Cancer Diagnostic Service within NHS Fife. It is recognised that NHS Fife's model is playing a crucial role in helping better understand how this fast-track diagnostic model could be optimised in NHS Scotland, especially for those with non-specific symptoms suspicious of cancer. The Cancer Improvement and Earlier Diagnosis Team provided nonrecurring revenue funding to

continue delivery of the Rapid Cancer Diagnostic Service. This funding will cover your RCDS until March 2025.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report aims to inform stakeholders of the key findings from the University of Strathclyde evaluation of the NHS Scotland RCDS pilots.

The Interim Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk) and the Final Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk) are now both published (Appendix 1 & 2).

2.2 Background

The aim of the RCDS service was to develop a person-centred diagnostic pathway and provide primary care with a new route through which to refer **patients with non-specific symptoms**, such as unexplained weight loss, pain or fatigue that may be suspicious of cancer. The pilot programme was planned to run from June 2021- March 2024.

Roll out of the RCDS model is planned for all health boards by 2025-6 and is a key part of the NHS Scotland cancer strategy (2023). The second wave pilots in Borders and

Lanarkshire are currently using NHS Fife's virtual model and training packs to develop their own services.

The Centre for Sustainable Delivery commissioned the University of Strathclyde to conduct a detailed evaluation of Scotland's RCDS's (interim report November 2023) and a further report economic evaluation which was submitted in December 2023.

The report reviewed the 5 pilot boards:

- Dumfries & Galloway - Face to face clinic (3-4 slots per week) (GP CT requesting available)
- Ayrshire & Arran - Virtual model with consultant MDT review (GP CT requesting available)
- Fife - Virtual Nurse led service (Colorectal Lead)
- Lanarkshire - Virtual Nurse led service (Colorectal Lead)
- Borders - Virtual nurse Led Service (GP lead)

Interim report:
Interim Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk)
(Appendix 1)

Key points:

- Cancer incidence 12.1%
- Mean duration of pathway was 13 days (Interquartile range 9-17 days)
- Patient centred care with high satisfaction levels with single point of contact.
- Rapid turnover of referrals – vetting and CT scanning
- 30% redirection (66% redirected to alternative cancer pathway)
- Socioeconomic deprivation – Scottish Index of Multiple Deprivation (SIMD) move towards SIMD1&2 (Mean 2.1)
- Broad range of Cancers detected (n=17 types) (lung, hepatobiliary and urology)
- Presentation - unexplained weight loss, GP gut feeling, Fatigue, unexplained pain, new unexplained laboratory results
- Steady increase in service numbers over initial 12 month period.
- High levels staff satisfaction in service provided.
- Low Did Not Attend (DNA) rate

NHS Fife Interim report 2021-23 (Appendix 3) gives a more comprehensive evaluation of the service in NHS Fife.

An NHS Fife cost effectiveness report submitted to SLT (November 2023) outlined the potential cost impact of withdrawing the RCDS pathway and the impact on General Surgery / Planned Care (Appendix 4).

- The cost of the service in NHS Fife is £252,670 (2024-5) with additional £60,258 in radiology support.
- The comparator models indicated additional costs of £125,716 to £186,236 would be incurred to re-provide the service with consultant cover and without the levels of service provided by the RCDS (no single point of contact).

A decision was taken to continue to provide the service in 2024-5 and await the final Strathclyde report and the evaluation of The gastro-intestinal (GI) RCDS service. The Centre for Sustainable Delivery funding was extended to all pilot boards up to September 2024 (awaiting Secretary of State decision on RCDS funding and roll out).

The RCDS GI Report included in Appendix 5 for review includes an additional 700 patients within the existing RCDS funding envelope.

2.3 Assessment

[Final Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk)](strath.ac.uk) (Appendix 2)

CfSD commissioned the University of Strathclyde to conduct an evaluation of Scotland's Rapid Cancer detection Service (RCDS).

- Mean time for the diagnosis/exclusion of cancer 16.3 days (well within target of 21days).
- Cancer incidence 11.9% (pre-malignancy in 6.4%)
- Enhanced patient experience, satisfaction and equity of access.
- CT scanning central diagnostic tool used
- GP gut feeling, unexpected laboratory results, nausea/anorexia and cognitive impairment positively correlated with a cancer diagnosis.
- RCDS found to be cost effective (particularly NHS fife model) – utility gains from a faster diagnosis, reduced anxiety and uncertainty by patients.
- Insufficient evidence to directly compare against a GP direct access service and RCDS capable of managing a complex workload (increased use of RCDS over time in units with GP direct access). Additional delays in GP direct access following a CT diagnosis/onward referral.

Optimal Components:

- Vetting and triage by RCDS team
- Personalised single point of contact for each patient
- Enhanced Patient experience
- Coordination of testing (low DNA rate)
- Diagnostic decision making by RCDS team and MDT
- Appropriate onward referral by RCDS team

In terms of the Institute for Clinical and Economic Review (ICER) (from Appendix 2), NHS Fife's RCDS pathways was compared to their pre-existing general surgery pathway. RCDS was found to be cost effective using a willingness to pay threshold of £20k. The mean cost difference per patient between RCDS and its comparator was £135, with a mean time to outcome difference of ~75 days. This resulted in a mean ICER of ~£5.5k.

Overall, these findings are in line with the main conclusion of the study by Sewell et al. (2020) on the cost effectiveness of the pilot Rapid Diagnosis Centre (RDC) in Swansea Bay University Health Board in Wales. For example, the Mean Cost per RCDS patient in the base case analysis for NHS Fife is £640, with a mean time to outcome of 13.6 days. This can be compared to the Mean Cost per RDC patient for the case of 2.78 patients per clinic (excluding patients who required further investigations) in Swansea Bay University Health Board of £1068, with a mean time to diagnosis of 5.9 days.

Additional scenarios were also run for NHS Fife in the evaluation, some to increase the number of referrals per week to infer the optimal number in terms of cost-effectiveness. This suggested that RCDS at NHS Fife could run with a mean of 22 patients per week

whilst remaining within the 21-day target, with an overall ICER for comparison of only £183. An additional scenario was also conducted to reflect recent changes at NHS Fife which has resulted with RCDS resources being shared with other cancer pathways to give reduced resource (and hence cost) to the RCDS pathway.

The RCDS in Fife currently receives 80 referrals per month with an additional 60 upper gastro-intestinal/hepatobiliary referrals. This additional capacity has been utilised within the existing RCDS staffing model (see attached RCDS Gastro-intestinal model, Appendix 5).

Overall, the economic evaluation of NHS Fife's RCDS was extremely favourable in term of its ICER, reduction in the pathway and cost per patient. To create a sustainable model additional staffing was required however this additional capacity has been utilised cost effectively in expanding the service to include upper gastro-intestinal and hepatobiliary referrals.

The national Centre for Sustainable delivery is working towards a Scottish Government commitment to achieve population coverage to a Rapid Cancer Diagnostic Service by Spring 2026 and following formal evaluation by the University of Strathclyde it was agreed that a new Working Group would be established to oversee the implementation of further RCDSs and monitor the RCDSs already established.

NHS Fife Population Health and Wellbeing Strategy team included a case study from RCDS in the strategy. In the next update they are keen to highlight the impact RCDS has had on deprivation, focusing on health and inequality aspects.

Funding has been approved for the Rapid Cancer Diagnostic Service within NHS Fife. It is recognised that NHS Fife's model is playing a crucial role in helping better understand how this fast-track diagnostic model could be optimised in NHS Scotland, especially for those with non-specific symptoms suspicious of cancer. The Cancer Improvement and Earlier Diagnosis Team provided nonrecurring revenue funding to continue delivery of the Rapid Cancer Diagnostic Service. This funding will cover your RCDS until March 2025.

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 poster highlighting that traditional consultant-led cancer pathways are under significant pressure, making it challenging to maintain consistency amidst increasing healthcare demands. Our aim was to develop a hybrid nurse-led, person-centred gastro-intestinal cancer diagnostic pathway that offers a coordinated and faster approach to vetting, triage, and diagnosis was submitted to the NHS Scotland Event June 2024 Planning for the Future: Delivering Health and Care Services through Innovation and Collaboration. NHS Fife Realistic Medicine Team is referencing this model as an example of embedding Value Based Health and Care.

2.3.2 Workforce

Current workforce funded by non-recurring revenue to cover RCDS until March 2025.

2.3.3 Financial

Overall, the economic evaluation of NHS Fife's RCDS was extremely favourable in term of its ICER, reduction in the pathway and cost per patient. To create a sustainable model additional staffing was required however this additional capacity has been utilised cost effectively in expanding the service to include upper gastro-intestinal and hepatobiliary referrals.

The Cancer Improvement and Earlier Diagnosis Team provided nonrecurring revenue funding to continue delivery of the Rapid Cancer Diagnostic Service. This funding will cover your RCDS until March 2025.

2.3.4 Risk Assessment / Management

All Boards were commissioned to develop an Annual Delivery Plan to drive forward change across health and social care within NHS Fife within the context of a challenging financial situation.

Identified risks or issues of importance will be escalated to the NHS Fife Cancer Governance and Strategy Group.

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

RCDS supports equality and diversity by delivering personalised care utilising patient navigators, practise shared decision making and tackle unwarranted variation in health, treatment, and outcomes, therefore contributes to reduce harm and waste and deliver better value care – better value for patients and for our health and care system.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards
Dr Christopher McKenna, Medical Director

2.3. 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.

- Senior Leadership Team
- Cancer Leadership Team
- Cancer Governance & Strategy Group Meeting
- Surgical Directorate Clinical Governance meetings

2.4 Recommendation:

- **Discussion** of the Final Strathclyde University Evaluation Report
- **Assurance** – Members are asked to take a **"moderate"** level of assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1 can be found at this link: Interim Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk)
- Appendix 2 can be found at this link: Final Report of the Evaluation of Rapid Cancer Diagnostic Services (strath.ac.uk)
- Appendix 3 NHS Fife Rapid Cancer Diagnostic Service Report (June 2021-June 2023)
- Appendix 4 SLT financial Impact of RCDS (November 2023)
- Appendix 5 NHS Fife RCDS –GI report

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NHS (National Health Service)

Fife's Rapid Cancer Diagnostic Service

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1. Introduction

The Scottish Referral Guidelines for Suspected Cancer provide GPs with set criteria of symptoms for each type of cancer that can be used to flag a patient for referral to secondary care for further investigation. Current Scottish Government Local Delivery Plan (LDP) Standards stipulate that 95% of patients should wait no longer that 62 or 31 days for cancer treatment.

However, patients presenting to their General Practitioner (GP) with non-specific symptoms owing to an underlying malignancy, such as weight loss, fatigue, and nausea, do not always meet criteria for referral to a USC pathway.[1] In such cases, it falls to primary care to coordinate several diagnostic tests while retaining full clinical responsibility for the patient. This often results in delayed diagnosis, onward sequential referrals to multiple specialties, as well as unnecessary or inconclusive examinations resulting in poorer patient experience and outcomes.

NHS Fife established an award-winning Rapid Cancer Diagnostic Service (RCDS) in June 2021. The RCDS provides primary care with an alternative route to refer patients with non-specific symptoms which are causing their GP concerns of malignancy. Patients referred to the RCDS receive co-ordinated examinations and investigations based on their needs with rapid reporting of results. In doing so, it ensures those identified at higher risk of a potential cancer diagnosis are expedited on to an appropriate pathway, so they receive the required treatment and care earlier than would otherwise have been feasible.

The RCDS model is being rolled out nationally by NHS Scotland, as part of the NHS 10-year cancer strategy.[2] The cancer strategy sets out the long-term plan to facilitate the faster diagnostic standard of 28 days, improve patient experience and reduce geographic variations in access to health services.

Furthermore, the implementation of the RCDS is aligned with the ambitions of NHS Fife's recently published Population and Health and Wellbeing Strategy (2023-2028)[3] and commitments set out within NHS Fife Cancer Framework (2022-2025) which embraces opportunities to deliver new ways of working and improve cancer care. We are reminded daily of the pressures and spending constraints challenging NHS Fife, including increasing demand for services, a real-terms reduction in funding, combined with high inflation and rising interest rates. Faced with these pressures it is essential that we deliver value-based health and care.[4]

1.1 RCDS pilot sites

Three health boards are currently piloting the RCDS model in Scotland

Board	Model	Pathway
NHS Fife	Nurse-led triage and clinical assessment	21 day
NHS Dumfries & Galloway	Medical Led triaged and clinical assessment combined with CNS	7 day
NHS Ayrshire & Arran	Virtual Multidisciplinary Team and ACNS	21 day

1.2 NHS Fife's RCDS service model

NHS Fife's RCDS was launched in June 2021 and operates within the Victoria Hospital, Kirkcaldy. The service incorporates both the Danish and Welsh models modified for local use in NHS Fife.[5, 6]

An overview of the RCDS service is presented in Appendix 1. The service is open to referrals from all GP practices and Nurse Practitioners (NP) in primary care for patients over the age of 18 who do not meet the criteria for a specific urgent suspected cancer (USC) pathway. Moreover, the RCDS referral acknowledges GP 'gut feeling' that if the patient is experiencing non-specific symptoms and the GP suspects an underlying cancer diagnosis, they can be referred to the service.

Appendix 2 provides a more detailed description of a patient's journey through the RCDS pathway. A Patient Navigator (PN) coordinates the pathway, including scheduling diagnostic and follow-up appointments. The Advanced Clinical Nurse Specialist (A)CNS has responsibility for vetting and triage of referrals and rapid communication to the patient regarding confirmation or exclusion of a cancer diagnosis.

As part of the RCDS protocol, the GP records the frailty score of the patient and undertakes a blood bundle (Appendix 1) prior to the referral to the service so the results are available when the patient is comprehensively assessed. All referrals are initially vetted by the (A)CNS following their receipt into secondary care to ensure they are suitable for the pathway. Vetting a referral will take on average 5-10 minutes per referral with an average 20 referrals per week. The Scottish Government criteria is that patients are vetted within 72 hours of referral.[1]

Any referrals deemed to meet the criteria for an urgent site-specific pathway or more appropriate for another specialty are either forwarded on to the relevant speciality or directed back to the referrer as they do not meet the RCDS criteria.
For patients eligible for the RCDS pathway, a standard has been locally agreed in that most patients will be contacted by the service within 48 (working) hours of referral to introduce effective and informative promotion of the service and patients are sufficiently well informed with realistic expectations of what the service entails. The exception to this standard are for referrals received on a Friday where the patient will be contacted at the beginning of the next week.

GPs are asked to undertake a physical examination as part of the inclusion criteria for the referral. Once the referral is received patients are clinically assessed, usually by telephone. The outcome of the (A)CNS assessment is either triaged investigation or diagnostic investigation requested. The assessment is carried out in 25 minutes undertaking a full medical history, request for a Computer Tomography (CT) Chest, Abdomen and Pelvis (CAP); and a further 5 minutes to update the database and record the outcome on Trackcare. If the patient has a cognitive or hearing impairment, a learning difference or any neurodivergence, a face to face appointment may be more beneficial. The PN reconnects with the patient to advise of the test, the appointment date and time. The PN also collaborates with a dedicated CT radiology booking officer to aid in the scheduling of CT scans which are undertaken for all RCDS patients.

A CT CAP is undertaken within 7-10 days, if this is the preferred imaging. As a result of further training, the ACNS can assess suitability for other investigations and can request Magnetic Resonance Imaging (MRI), endoscopies, ultrasound, and x-rays as first-line investigations if required. Results clinics are held over 5 full-day clinics, aiming to provide results within 48 hours of testing. A mixture of face to face and telephone appointments are provided, of which timings can vary as below:

- Telephone: 5-10 minutes depending on symptoms and need for further referral, such as lifestyle medicine, secondary care.
- Face to face: if cancer, at least 30 minutes; this can stretch longer depending on emotional response and support.

- Face to face: if benign and complex, 20 minutes as bloods may need to be completed, or request further investigations such as MRI, or specialist bloods.

A Multidisciplinary Team (MDT) meeting between the lead clinician, ACNS, CNSs and PNs is also held weekly for more complex presentations to discuss appropriate next steps. Once the test results are available, the patient is booked into the next available RCDS clinic slot by the PN, with the intention that the patient is seen within 21 days from referral.

1.3 Principles underpinning delivery and approach of the RCDS

The model developed in Fife is a relational leadership styled model by the clinical lead to the nurse-led service supported by a PN.[7] This ensures a relational process of a team working together to accomplish change or make a difference based on the following primary components:

- Shared purpose: Having a common set of values and vision to move an initiative forward.
- Empowerment: Sharing power with others to embrace what they have to offer.
- Inclusivity: Welcoming and open to diverse points of view and diverse identities.
- Process-Orientation: The focus is on the patient and how the professional groups work together.

This can be translated into the patient and significant other being at the centre of care, with the (A)CNSs and PNs providing consistent coordinated care to a patient through a unified communication strategy, and information sharing amongst all multidisciplinary professionals. This approach promotes the conditions for care that is safe, effective, efficient, and patient-centred and recognises each team member's unique expertise and full scope of practice.

1.4 Current Staffing

The RCDS staffing model has a 0.1WTE GP with a 0.1WTE Clinical lead with 1 advanced clinical Nurse Specialist, 2 trainee Advanced Clinical Nurse Specialist and 3 Patient Navigators supported by secretarial support

- 0.1WTE GP
- 0.1WTE Clinical Lead (Consultant Surgeon)
- 1.0 WTE Advanced Clinical

1.5 Tests of change

During the RCDS pilot, the service has initiated various tests of change. One is testing the concept of the principles of the 'RCDS model' within three USC site-specific cancer pathways, namely hepatobiliary and oesophago-gastric (started in March 2023), and colorectal (started July 2023). The aim of these tests of change is to better coordinate the vetting, triage, and diagnostic processes involved in the diagnosis of GI cancers and improve support to patients on these USC pathways by integrating learning from the RCDS model. In so doing, it is hoped this will reduce the time to diagnosis and treatment, improving compliance to national cancer waiting time standards. A third test of change has been introduced utilising the role of the PNs who provide a holistic service by offering lifestyle medicine clinics. Lifestyle Medicine is an evidence-based discipline which aims to support patients to prevent, manage and reverse certain chronic conditions, using supported behaviour change skills and techniques to create, and sustain lifestyle changes. The aim is to offer RCDS patients who remain symptomatic, despite having a cancer or benign diagnosis excluded, the opportunity to explore lifestyle factors which may be affecting their health, using a personalised approach and by focussing on the four pillars of health (relax, eat, move, sleep). This intervention commenced in June 2023.

1.6 Evaluation of the RCDS pilots

The Centre for Sustainable Delivery invited the University of Strathclyde to conduct an evaluation of Scotland's RCDS pilots. The interim report, which was published in 2022, analyses the nationally agreed minimum datasets collected by each of the three early-adopter Health Boards (Fife, Ayrshire and Arran, and Dumfries and Galloway) to date.[8] It also presents data from the patient and primary care surveys, and the report discusses findings from an initially limited set of qualitative interviews conducted by the University of Strathclyde in summer and autumn 2022 with RCDS patients and a range of healthcare professionals.

The key objective of the final evaluation, which is anticipated in November 2023, will provide a micro-level analysis of resource inputs and costs, as well as quality-of-life benefits accruing to patients from rapid diagnosis, so that the efficiency and cost effectiveness of the new RCDS pathways can be accurately evaluated. The University of Strathclyde team will also continue to explore the patient and professional experiences of the RCDS pathways, including their equity, accessibility, and value. Research will focus on the optimal components of the RCDS pathways, in addition to the more in-depth health economic analysis. This will then inform recommendations for the wider expansion and delivery of the RCDS model across Scotland.

1.7 Scope and added value of this report

This report aims to provide more granular detail on the operation of the NHS Fife RCDS model from its inception up to June 2023 and key lessons learned around implementation. Our report also compares the operation of the RCDS with the standard USC pathways, particularly in terms of equity of access, and provides qualitative insights obtained from service providers and users. This also meets the priority within NHS Fife's Cancer Delivery Framework for 2023-2024, which is to review the impact of the RCDS with a view to expanding to other specific tumour sites. The tests of change within RCDS are out of scope for this report but will be reported on in autumn 2023 and spring 2024.

2. Methods

Data were collected on the activity and performance of the RCDS for patients referred June 2021 – June 2023. Several anonymised datasets provided by the cancer waiting times and performance team were used as part of the analysis.

- An electronic dataset, maintained within the RCDS, of all patient referrals received from inception until 30th June 2023. Data recorded in this dataset includes basic patient demographic information (age, gender, postcode), referral and appointment dates, patient diagnoses and outcomes (in terms of further referrals).
- Routinely collected hospital activity data for those patients known to have had an RCDS appointment between 1 June 2021 and 30 June 2023 which includes patients not vetted, recall lists, deceased patients, previous day activity, patients admitted within 10 days of referral.
- Linking patient data to Scottish Index of Multiple Deprivation (SIMD 2020) .
- One of the primary drivers for implementing RCDS was to improve patients' experience. Qualitative feedback was sought through Care Opinion, providing an opportunity to review and improve this evolving service care.

Opinions of the RCDS from the primary care community were also sought. An online survey was conducted in 2022 and re-run in July 2023, containing both open and closed questions. A

revised questionnaire had also been issued in March 2023 to gain more detail on some of the less positive comments identified during the first survey.

The RCDS clinical team met every week to encourage a culture of reflective practice and lesson-learning. It also hosted monthly meetings to discuss opportunities for service improvement and tests of change. Some of the learning from these meetings has been captured in this report within the findings.

Finally, a set of case studies were developed which provide some helpful real-life examples of how the pathway worked in practice (Appendix 3).

3. Findings

3.1 Referrals to RCDS

Between 1 June 2021 and 30 June 2023, the total number of patients referred to the RCDS was 1650. Figure 1 provides the number of referrals made by month and year. This has been steadily increasing over time since the RCDS started in 2021.

Figure 1: Number of referrals to RCDS by month and year

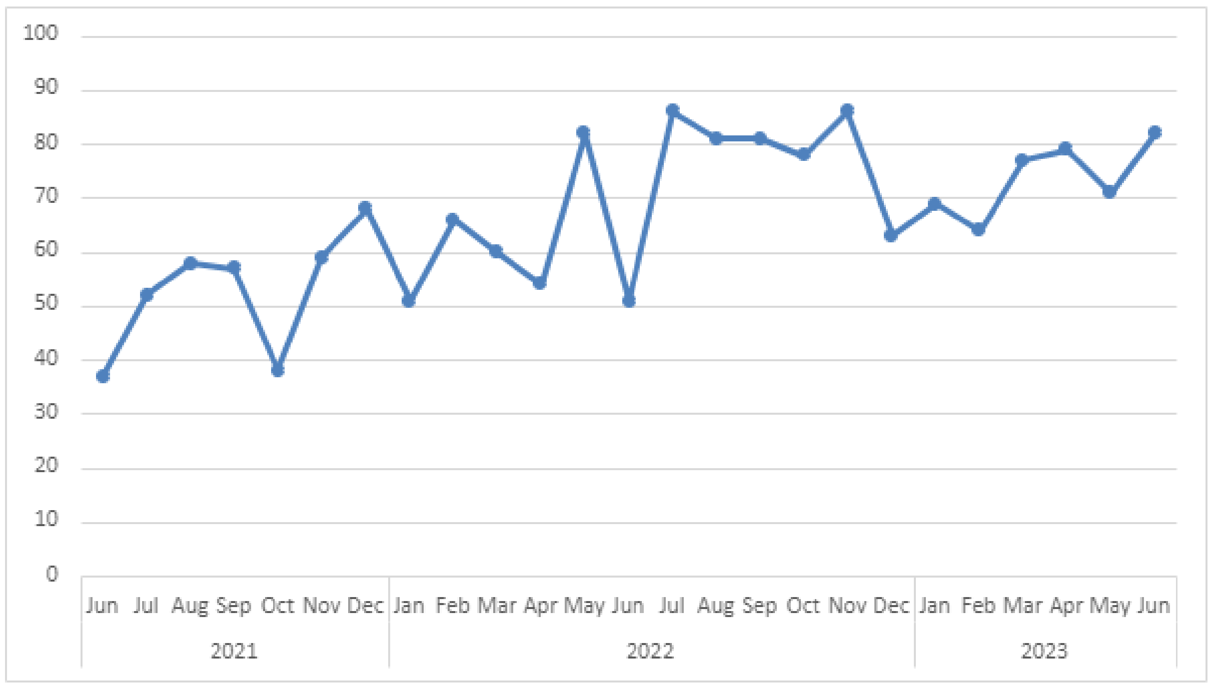
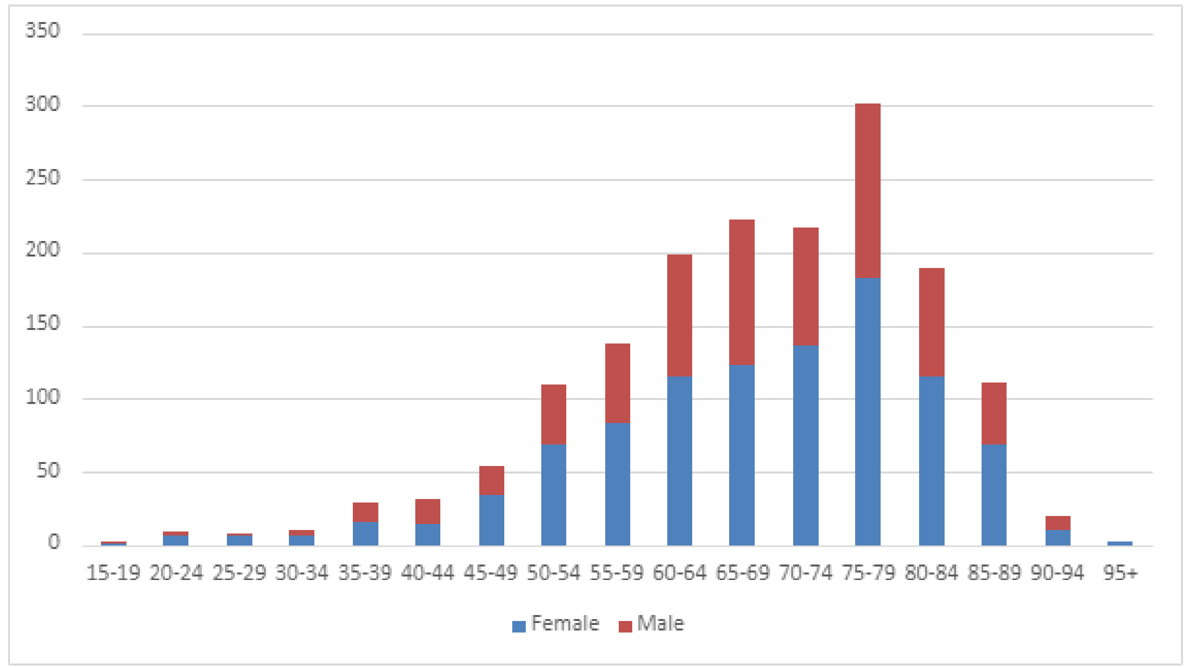


Figure 2 below shows that most referrals were made up of adults over 60 years, with the number peaking in the 75-79 year age group. A greater proportion of referrals were also female (60%).

Figure 2: All RCDS referrals by age and sex



When examining referrals by Scottish Index of Multiple Deprivation (SIMD 2020) quintiles (20% of the population in each quintile), most patients were from SIMD quintile 1 (24.4%), the most deprived areas, followed by SIMD Q2 (22.1%), SIMD Q3 (19.0%), SIMD Q4 (17.8%) and SIMD Q5 (16.2%).

Blood bundles completed for patients for RCDS pathway

Less than a quarter of referrals made had the RCDS blood bundle carried out at the point of referral (Table 1). The proportion for referrals accepted onto the pathway was slightly higher at 28% (35% if partially complete is included).

Table1: Referrals with RCDS blood bundle available at referral

Status (grouped)	No	Yes	Partial	NA	Total	%No	%Yes	%Partial
Pathway complete	671	281	68	1	1021	66%	28%	7%
Pathway terminated*	25	14	7		46	54%	30%	15%
Redirected**	470	69	15	6	560	85%	12%	3%
Other***	11	12	0		23	48%	52%	0%
Total	**1177**	**376**	**90**	7	**1650**	**72%**	**23%**	**5%**

*Terminated – This can either be by staff following initial call, i.e too frail to continue pathway, needs hospital admission or cancelled by patient cl.
**Redirected – either to benign pathway, site specific pathway, or to GP, does not meet RCDS criteria
***Other e.g. vetted to CT (see Table 2)

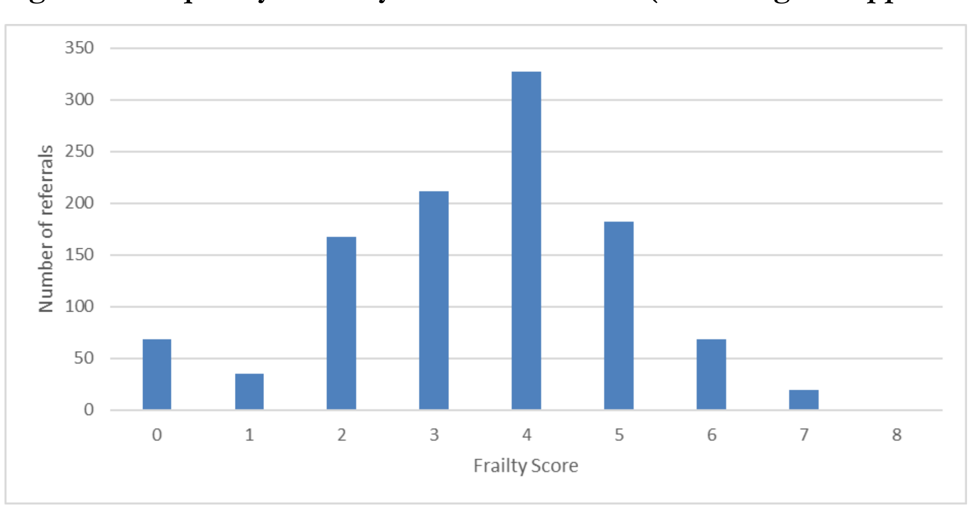
Figure 3 shows three-month rolling averages of the percentage of blood bundles that were either complete or partially complete for referrals accepted onto the pathway. The percentage has varied over time, but more recent months show an increase in completed bundles, overall numbers were somewhat lower in the early stages of the project which can skew the data. Performance was also better at the outset, but the novelty of the pathway and lower number of referrals may have meant improved compliance at the outset.

Figure 3: Percentage of RCDS bundles complete or partially completed for accepted referrals as a three-month rolling average

Frailty scores

In general, frailty was not well documented by GPs, with 35% lacking status against this in the records. However, of those with no frailty score recorded, the majority (95%) had a "redirected" status (i.e. an alternative pathway was more appropriate). Where a frailty score was present, 4 was the most common with 31% of referrals, the middle frailty scores being much more common than very high or very low scores (Figure 4).

Figure 4: Frequency of frailty scores in referrals (excluding not applicable)



*Frailty score varies from 0=very fit to 9=terminally ill

Patient outcomes from referrals

Out of 1650 patients referred, 1067 (64.7%) were eligible for the pathway (Table 2). Out of those accepted onto the RCDS pathway, 130 (11.9%) have been diagnosed with a malignant cancer.

Table 2: outcome of patient referrals to RCDS

Outcome from RCDS	**No. of patients**	**% of patients**
Awaiting vetting	2	0.1%
Vetted to CT (Computerised Tomography)	4	0.2%
CT booked	13	0.8%
CT complete - further test needed	4	0.2%
Pathway complete	962	58.3%
Pathway complete - further test required	59	3.5%
Pathway terminated	46	2.8%
Redirected - a serious non cancer diagnosis is highly likely	15	0.9%
Does not meet RCDS criteria	216	13.1%
Redirected - meets criteria for benign pathway	14	0.9%
Redirected - meets criteria for site specific pathway	275	16.7%
Redirected - patient seen by RCDS within last 3 months with no new symptoms	4	0.2%
Redirected - patient unable to proceed	11	0.7%
Unfit for pathway*	25	1.5%
Total	**1650**	**100%**

*Either hospitalised already or too frail

In general, table 3 indicates that RCDS appointments were well attended. The Did Not Attend (DNA) rate ranged from 0% most months to 2.1% at most per month when considering both new and return patient appointments. Figures were collected from July 2021 once the clinic template was set up in July 2021

Table 3: DNA rates to RCDS appointments

Month and year	**New Patient**	**Return Patient**	**DNA Rates Total**
October 2021	0.0%	0.0%	**0.0%**
November 2021	0.0%	0.0%	**0.0%**
December 2021	0.0%	1.9%	**1.9%**
January 2022	1.1%	0.0%	**1.1%**
February 2022	0.0%	0.0%	**0.0%**
March 2022	1.4%	0.8%	**2.1%**
April 2022	1.6%	0.0%	**1.6%**
May 2022	0.0%	1.8%	**1.8%**
June 2022	1.3%	0.8%	**2.1%**
July 2022	0.0%	0.9%	**0.9%**
August 2022	0.0%	0.7%	**0.7%**
September 2022	0.0%	0.8%	**0.8%**
October 2022	0.0%	0.0%	**0.0%**

Month and year	New Patient	Return Patient	DNA Rates Total
November 2022	1.0%	0.0%	**1.0%**
December 2022	0.0%	0.0%	**0.0%**
January 2023	0.0%	0.0%	**0.0%**
February 2023	0.0%	0.0%	**0.0%**
March 2023	0.0%	0.0%	**0.0%**
April 2023	0.0%	0.0%	**0.0%**
May 2023	0.0%	0.9%	**0.9%**
June 2023	0.0%	0.0%	**0.0%**

Table 4 shows that of all cancers diagnosed the most common cancer identified through the RCDS was lung cancer, followed by hepatobiliary cancers then colorectal cancer.

Table 4: Breakdown of cancer diagnosis

Cancer diagnosis	No. of patients	% of patients
Lung	24	20.0%
Upper GI Hepatobiliary	19	15.8%
Colorectal	12	10.0%
Renal	12	10.0%
Cancer of Unknown Primary	11	9.2%
Lymphoma	8	6.7%
Breast	8	6.7%
Upper GI Hepatocellular carcinoma	5	4.2%
Myeloma	4	3.3%
Bladder	3	2.5%
Ovarian	3	2.5%
Upper GI Gastric	2	1.7%
Upper GI Oesophagogastric	2	1.7%
Endometrial	2	1.7%
Other	2	1.7%
Sarcoma	2	1.7%
Leukaemia	1	0.8%
Total	**120**	**100%**

3.2 Results clinics

Between June 2021 and June 2023, 477 results clinics were held. Patients were offered the option of telephone, in person or virtual appointments (Table 5). The total number of appointments offered was 4336.

Table 5: Results clinics by appointment type

Appointment type	Attended	DNA (%)	Proportion of total appts offered
Telephone	4157	17 (0.4%)	96.2%
Face to face	124	0	2.9%
Near Me	38	0	0.9%
Total	**4336**	**0.4%**	**100%**

Telephone appointments were the most popular option. However, the uptake of Near Me (a video service enabling people to attend appointments from home) was consistently low. This was on account of technical issues experienced by staff and service users in accessing calls as well as poor quality sound. As a result, this option was less favoured by the service provider.

3.3 Waiting times within RCDS

RCDS has a 21 days standard for confirming or excluding a cancer. 94.8% of patients successfully complete the pathway within 21 days.

Figure 5: Waiting times within RCDS

Figure 5 provides an overview of waiting times within the RCDS pathway. Median waiting time from referral to first direct contact was within 2 days and compliant with the 48 hour standard. From implementation of RCDS, the shortest wait from referral to direct contact was 0 days and the longest wait from referral to first direct contact was 37 days noted over the Christmas period; however this has improved significantly over time.

Median waiting time for referral to first diagnostic test ranged between 6 and 12 days, while the shortest wait was 1 day and longest wait was 37 days, noted over the Christmas period.

The median waiting time between referral and end of pathway ranged between 10 and 16 days.. The longest wait time was 47 days, again over the Christmas period. Since then, staff are in place over Christmas ensuring no gaps in service provision.

3.4 Comparison of RCDS with USC pathways

Table 6 shows the breakdown by SIMD for diagnosed cancers under the USC and RCDS.

Table 6: Proportion of cancers by SIMD for USC and RCDS

	Proportion of population diagnosed with a cancer				
Pathway	SIMD 1	SIMD 2	SIMD 3	SIMD 4	SIMD 5
USC	21.0%	22.4%	19.6%	21.0%	16.0%
RCDS	26.7%	20.0%	15.8%	22.5%	15.0%

Table 7: Comparison of days of referral to diagnosis times for USC and RCDS:

Days from Referral to date of Diagnosis	**All USC**		**All RCDS**	
Day 0-31	75.0%	1453	96.7%	116
Day 32-62	19.4%	376	3.3%	4
Day 63-100	4.5%	87		
Day 101+	1.1%	22		
Total	**100%**	**1938**	**100%**	**120**

A 62-day standard is in place for an urgent referral for suspected cancer to the start of treatment. RCDS patients are currently not subject to the 62 day standard. While comparing days from referral to diagnosis for USC cancers and RCDS cancers a decision was made not to look at specific cancers due to the low numbers of cancer types diagnosed within RCDS. According to our analysis, the RCDS appeared to have diagnosed the majority of cancers by 31 days. However, it should be borne in mind that the numbers entering the RCDS were much smaller than those entering the USC pathways. No direct comparisons can be made between either service as USC cancer diagnosis are dependent on histology confirmation and RCDS utilises radiological diagnosis of cancer.

4. Feedback from service users'

Since the launch of RCDS service, NHS Fife has been proactively seeking patient feedback through Care Opinion. There have been 47 stories. The service received 16 stories in 2021, 25 stories throughout 2022 and 6 stories for the first six months of 2023. To date, the stories in this report have been viewed on 5,991 times.

The feedback received to date has been overwhelmingly positive with patients being most impressed with the staff both in RCDS and radiology, speed of test, communications received, and care given. This was summarised by one service user who described their experience of care as follows: *"It was like a whirlwind, not of destruction or confusion but reassurance and comfort."*

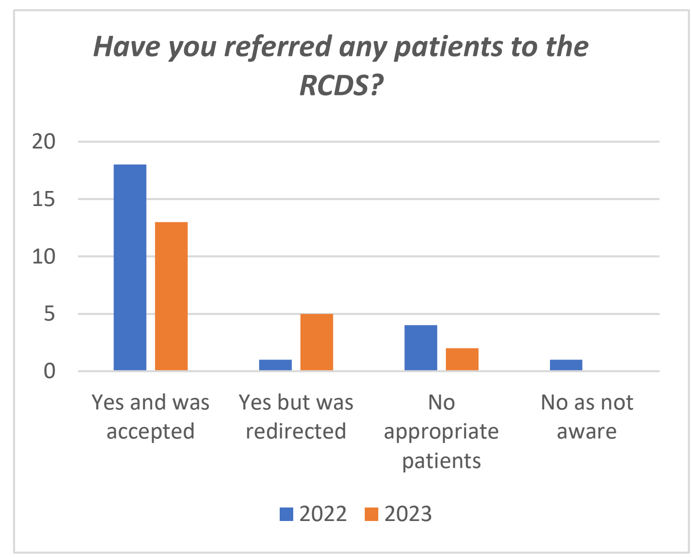
There were areas highlighted by service users where they felt improvements could be made notably communication, access to specialists, answers and call back. Only one patient commented that all of these were areas for improvement, while only 4 suggested improvements specifically around communication. These included quicker transfer of information between services, and better communication around waits for confirmed appointments with new specialists and follow up from primary care.

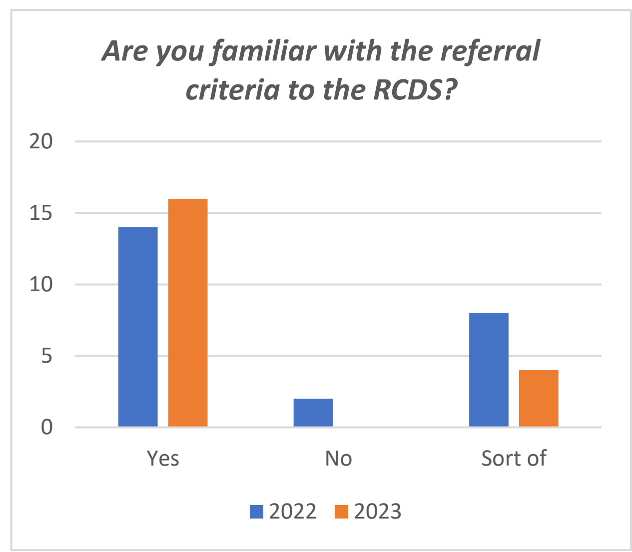
Further examples of stories and analysis obtained from Care Opinion are provided in Appendices 4 and 5.

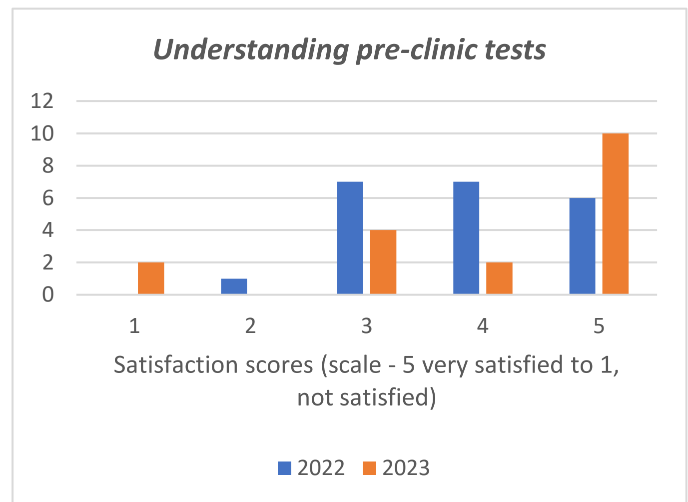
4.1 Feedback from GPs

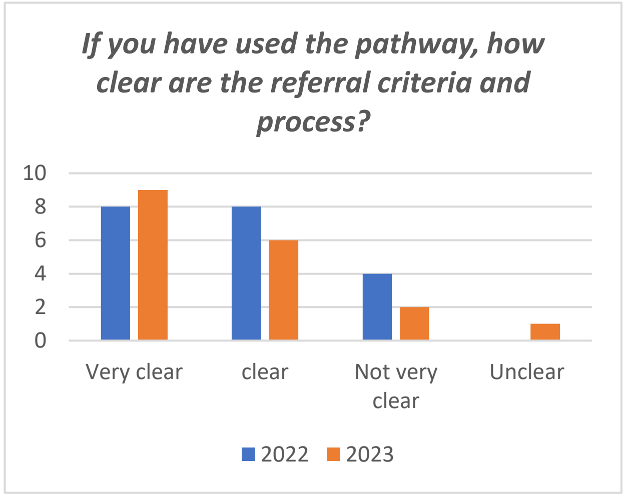
The first online survey of the RCDS in June 2022 yielded 24 responses, while a re-run of the same survey yielded 22 responses. Figures 6, 7 and 8 below compare results obtained from both surveys.

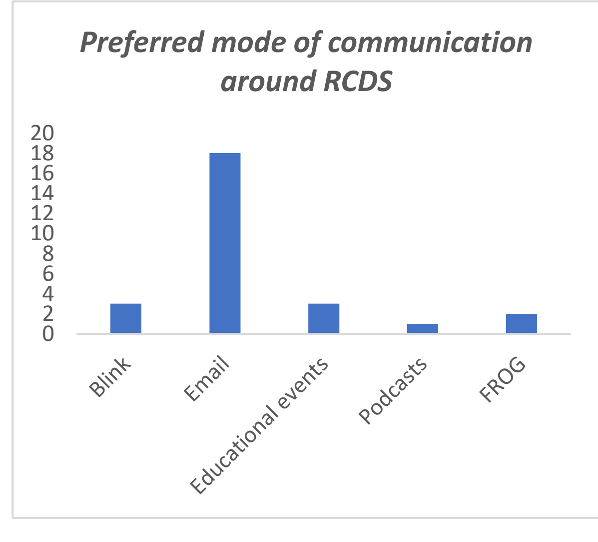
Figure 6: Awareness of RCDS and referral criteria by GPs





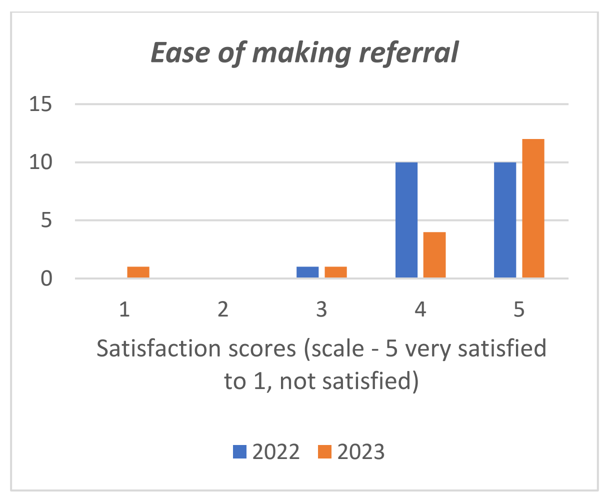


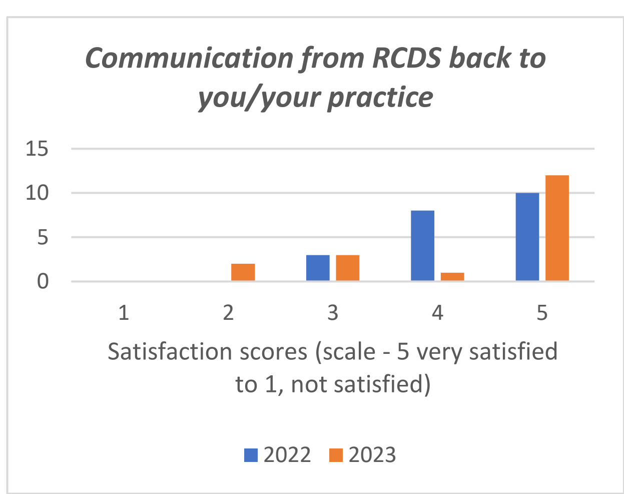


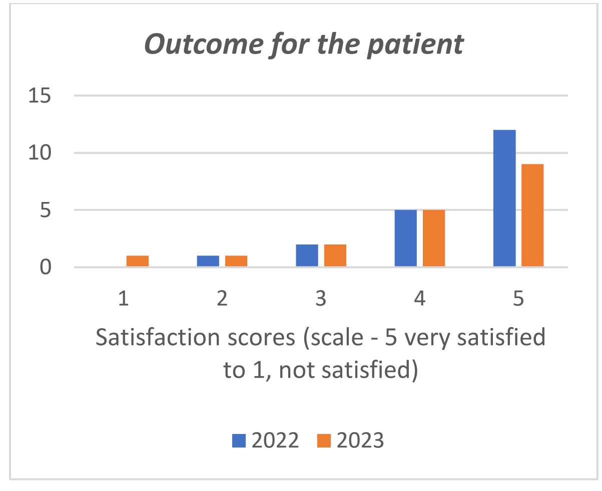


Other useful feedback on how to raise the profile of the RCDS included sharing anonymised case studies, statistics around the number of cancers diagnosis by the service and producing a short video and guidance for GPs providing guidance on how to use the pathway.

Figure 7: Feedback on using the pathway from GPs







Other qualitative feedback obtained on the pathway included a question around the added value of the RCDS if direct referral to CT is available to GPs. Interestingly; the response was mixed around the benefits.

Some GPs did feel the RCDS offered advantages e.g.:

"One patient I had a "gut feeling" about. I would likely have referred her to medicine of the elderly for review, but likely she wouldn't have been seen as quickly as she was by you." *"Very useful! Patient and doctors would have found it frustrating trying to sort out diagnosis which do not fit in to the usual referral criteria."*

2022

"It allows streamlining of investigations and avoids being passed from various specialties. I think of it as a one stop shop which allow a generalist perspectives with easy access to specialist investigations and discussions, which often is harder to access in general practice. Also often in general practice patients present with nonspecific symptoms or multi symptoms in the context of more worrying symptoms (weight loss / night sweats etc). When referring to specialties, I find my experience is that even when you direct to the most appropriate specialty based

on clinical picture, they only look at their specialty (i.e. respiratory will only do investigations required for lung cancer, CT chest and abdo) which is understandable, but will discharge the patient, who may continue to experience worrying symptoms. It can then lead the patient having non-conclusive results and may result in the patient being referred to different specialties with no continuity of care."
"Sometimes (the patient) does not meet criteria for direct referral to another specialty or CT."

2023

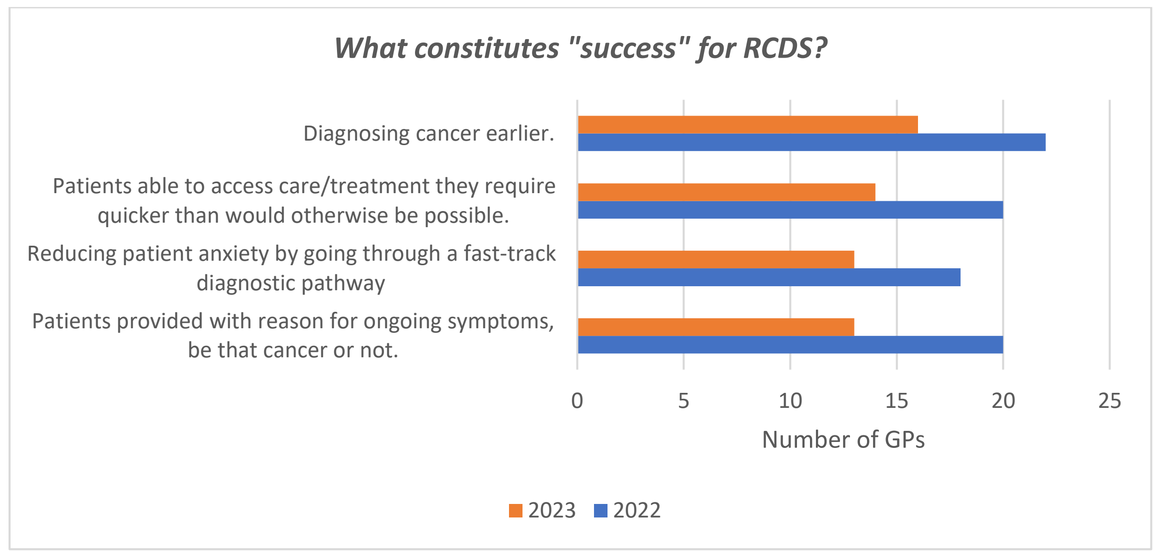
However, others were less convinced.

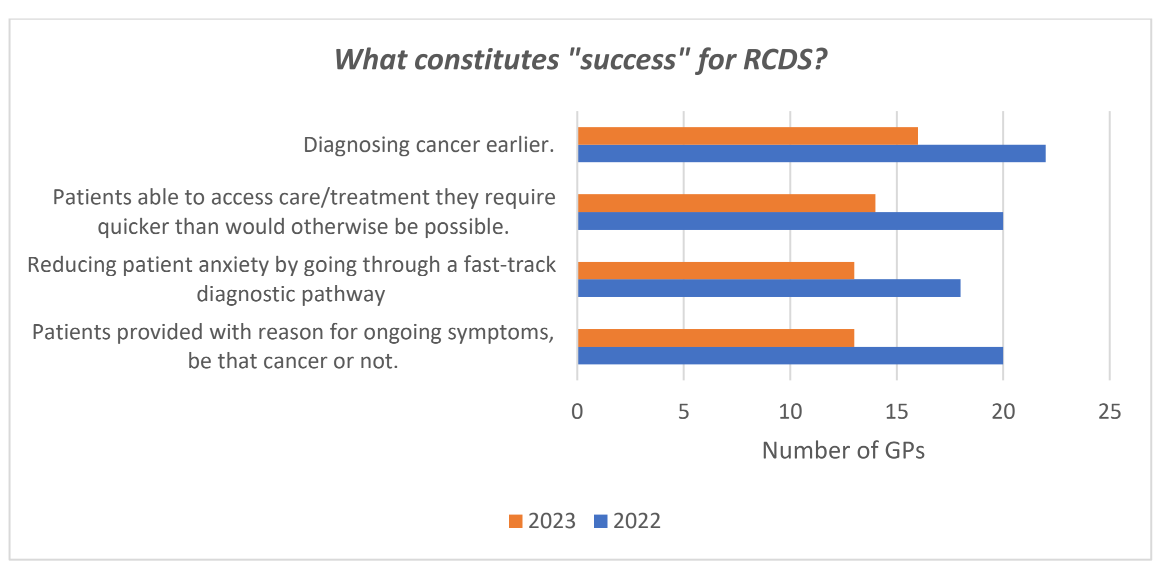
"No, no advantage-simply slows the process and paradoxically increases timeline to diagnosis from my experience thus far. Direct access-minimising the links in the chain is the clear winner to minimise delay."

"I'm not sure that RCDS is better than GP direct access to CT. In our area it seems patients are actually sometimes being seen by a clinician with less experience than a GP, and then once CT negative they don't offer much further thought about diagnosis sometimes requiring onward referral elsewhere. Surely direct access to CT CAP would cut out the middleman?"

2023

Figure 8: Overall opinion of GPs of RCDS pathway





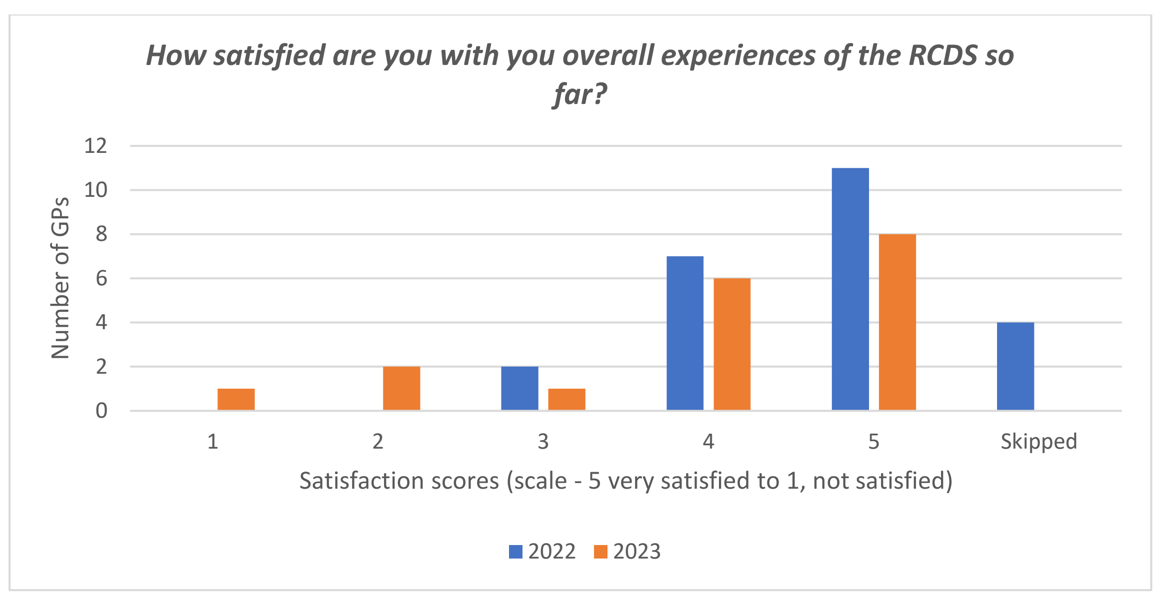


Figure 8 shows what GPs think success would look like for the RCDS. It can also be seen that most GPs referring to RCDS were either satisfied or very satisfied with the service.

Further constructive feedback was suggested on pathway improvement and how this could support other services is shown below.

"There are always some patients who you just know have likely cancer and need referral but cannot identify which speciality to refer them too. This is very helpful. Would be nice to have something similar for general medical complaints in younger people!."

"Would be good if could link up with CRU (Cancer Referral Unit) process."

"The referral criteria is quite clear but it would be really helpful if the criteria were on SCI gateway when referring to ensure the bundle has been done i.e. on the first page like when requesting an MRI there is a reminder of referral criteria."

2022

"Only issue is if assessment picks up something that needs further investigation with tests unavailable in primary care can cause problems as to who has ownership of it."

"Very polite and professional in their service -I just have not found the purpose of them where there is direct access for CT CAP."

2023

5. Lessons learned from RCDS meetings

5.1 Implementation challenges

- There were a few instances of patients who had opted for a phone call but had advanced cancer diagnosed from their CT scan and often needed further bloods etc. The appointment had to be changed to a face-to-face clinic appointment and it was not the best experience for the patient. To optimise patient experience, it was agreed by the team to wait until results were back from the CT scan and then make a results appointment with the patient based on what would be most appropriate for them. There was concern that making this change would add time on to the pathway but in fact it proved to be

beneficial. Patients without evidence of malignancy often have their results within 24 hours and those who do have a cancer are supported with a clinic appointment.

- Results are given within 48 hours. However, if a radiological investigation happens on a Thursday or Friday then the weekend is to be factored in as well as if a patient requests a face to face appointment. For an exceedingly small number of patients where CT CAP is not the most appropriate first line investigation this impacts on our time from referral to diagnosis.

5.2 Importance of mentoring

- The lead consultant for RCDS closely mentored the ACNS. This was invaluable as it empowered the ACNS to work more autonomously. For example, the lead consultant encouraged the ACNS to consider the next steps and undertake clinical decision-making under their guidance, which in turn promoted their own self-development.

5.3 Working in partnership with stakeholders

- Working in partnership with others was essential to the development, implementation, and ongoing delivery of the RCDS. For example, early discussions and funding from the initial proposal were secured to ensure RCDS had 5 protected slots per week with radiology. These slots have consistently been filled in a timely manner. RCDS systematically used a further 5 slots per week which were underutilised rapid access slots. RCDS frequently availed itself of the short notice cancellations on behalf of radiology.
- The operational clinical team have also been linking with secondary care specialties in raising awareness of the service (dietetics and palliative care most recently).

6. Education and Training

6.1 Training and skills of ACNS

- The characteristics of our nurse-led service typically involve carrying out roles which historically have been undertaken by the consultant surgeon. These are defined by direct vetting mechanism, assessment and technical skills, freedom to initiate diagnostic tests, increased autonomy, and scope for decision. The ACNS is expected to be able to work autonomously within the limits of their competencies, and they are expected to have the ability to rationalise choices and make difficult professional decisions. In terms of educational preparation there has been training in post and academic learning both in relation to clinical learning and leadership development. To practice at this advanced level, the ACNS has undertaken an MSc programme. Modules include advanced clinical decision making and practical implementation of skills have been supervised by a consultant colleague. In addition, the ACNS has been able to cascade learning to CNSs.
- The consultant for this clinical service worked collaboratively with the frontline ACNSs adopting a "yes we can" attitude. The approach used for learning and meeting the learning competencies for the role was through experiential learning at the inception of the service. This can be an effective teaching method for many because it can encourage creativity and foster reflective thinking.
- In addition to our formal education and experiential learning, self-directed learning has been the third strand of development. This has included working with other colleagues within the organisation. The PN and ACNS have given presentations on the RCDS to primary care, palliative care, and dieticians.

- Prior knowledge, relationships and experience are also essential components brought to bear in the role of ACNS. This role is not just about training, but the post-holder must have adept skills at relationship building and the ability to learn quickly.

6.2 Defining the role, education and skills of the PN

- The RCDS vision was to implement PNs to improve the experiences of patients and Health Care Professionals from referral to confirmation and exclusion of cancer diagnosis. PNs are crucial to promoting access to timely diagnosis by eliminating barriers to care and focusing on improving the delivery of care. The central components of the PN role are the delivery of coordinated services. It is also about improved information flows and maintaining trustworthy relationships with both patients and other services. Once in post the PN mapped out a communication strategy which is the foundation of the clinical component of the role.
- The PNs were key in ensuring a smooth transitioning to USC specific cancer pathway, freeing up ACNS and consultant time by undertaking necessary administrative tasks e.g. ordering any clinical work up that is required for the team and undertaking any clerical tasks from patient encounters.
- At the outset of developing this service it was recognised that communication training was essential as the patient-PN relationship may be influenced by the interpersonal communication skills and behaviours of the PN. The cancer nursing community and PN undertook a Good Conversations course which aims to build practitioners' confidence in holding outcomes focused conversations across a range of common and demanding situations. In addition, our PN undertook Effective Communication for Healthcare course (EC4H) provided by our palliative care consultants.
- A bank of "How to..." videos and administration were developed and produced by the forerunner PN which demonstrates how the PN carries out their job. This now forms the basis of a training package for all future PNs.
- The PNs currently map their skills onto the Macmillan Framework for Navigators and their recommended training meets the requirements set out in that document.

7. Planning for sustainability

- The future operational performance of the identified RCDS service was dependent on the ACNS and the PN. In response to this dependence, we noted succession planning within the team, and that will ensure its stability, growth, and future development. Based on our experience, we have also devised recommendations for expanding nurse-led services included establishing a framework, protocol templates and audit guidance (once this becomes business as usual) ensuring suitable organisational support.

8. Discussion

8.1 Operation of the service

Overall, the RCDS appears to have been positively received by patients, GPs, and other healthcare professionals. The fact that the number of referrals to the service has steadily increased since it started reflects greater awareness of it and that it is clearly filling a gap.

Most encouragingly, access to the service appears equitable, with data indicating good uptake by those living in all SIMD quintiles and low DNA rates. Although the numbers are low, the service appears to be consistently reaching and confirming cancer in those living in more deprived areas.

The pathway provides a timely service, with most patients with a cancer being confirmed within 21 days of referral.

The numbers of redirected and ineligible patients initially referred to the pathway reflect several complex issues. In some cases, better knowledge and awareness raising of eligibility could improve the quality of referrals. In other cases, patients were either too frail to undergo the full pathway or a non-cancer pathology was detected through testing. In addition, a small proportion of eligible patients did not have the complete RCDS blood bundle which may be explained by barriers to testing in primary care.

Concerns have been raised that the use of the RCDS could potentially disadvantage cancer patients who do not fit the referral criteria therefore as a result typically have to wait longer for clinical assessment and referral for diagnostic investigations.

In fact, the RCDS has positively influenced other practice in NHS Fife as evidenced by the prostate rapid access diagnostic clinic adopting a similar model. This pathway went live in July 2023, with the service provider noting they could *"see the benefits (of the RCDS model) to the patient in terms of continuity and touchpoints to enhance patient experience".*

NHS Borders, NHS Lanarkshire, NHS Lothian and NHS Lanarkshire RCDS services visited NHS Fife to learn from and take advantage of our comprehensive protocols and standards. The collective aim was to learn from our success to allow other Boards to also deliver a personalised, co-ordinated diagnostic approach for adults with non-site-specific symptoms to facilitate earlier cancer diagnosis and fast-track care.

8.2 Effectiveness and sustainability of NHS Fife RCDS model

Reorientating the model of care has been a distinguishing feature of our RCDS model. However, one of the key lessons from implementing the RCDS is that simply having services and trained people in place is not enough; both need to work together effectively to provide both logistical and relational care. The RCDS aspires to offer a model of care where patients know when and how they can get access to the right help, at the right time, in the right place. This report supports the positive impact of a nurse-led RCDS on outcomes and patient satisfaction.

The RCDS has also been efficient in the use of NHS resources. For example, the RCDS has been sustaining activity and diverting 700 referrals per annum from general surgery. The first 6 months of expansion into the GI cancers has resulted in diverting approximately 400 patients. It is anticipated that a further 800 referrals will be subsequently diverted from the colorectal service within the first six months of operation. Furthermore, it has been able to take up cancellation slots offered by radiology at short notice, which would have otherwise been wasted for the benefit of RCDS patients. This has been vital in meeting the 21-day target. Nonetheless, changes or introduction of other pathways e.g. optimal lung cancer pathway could mean reduced availability of cancelled slots for the RCDS service in future.

The sustainability of a nurse-led vetting service will depend on whether it is well supported by medical colleagues, as well as whether investment is made into the RCDS nursing service. 'Nurse-led' clinics have been in existence for many years and the benefits of timely intervention and cost-effectiveness cannot be disputed.[9] They also offer consistency, standardisation and continuity which can often be more challenging to provide through consultant-led services. However, the increasing healthcare demands of the population mean that there is a need to ensure specialty-run clinics are managed and staffed by appropriately trained professionals.

In conclusion, NHS Fife has demonstrated that the cancer pathway can be modified to deliver higher quality and responsive care with excellent patient feedback.

9. Recommendations

A set of key recommendations have been identified through this report:

9.1 Referral to pathway

- The modes of communication on RCDS should be reviewed to ensure GPs are reached through their most preferred options (e.g. combination of email and educational events – live/recorded).
- The RCDS GP should work with GPs on how to improve the completion of blood bundles and recording of frailty for eligible patients prior to referral to the RCDS.

9.2 Experience of pathway

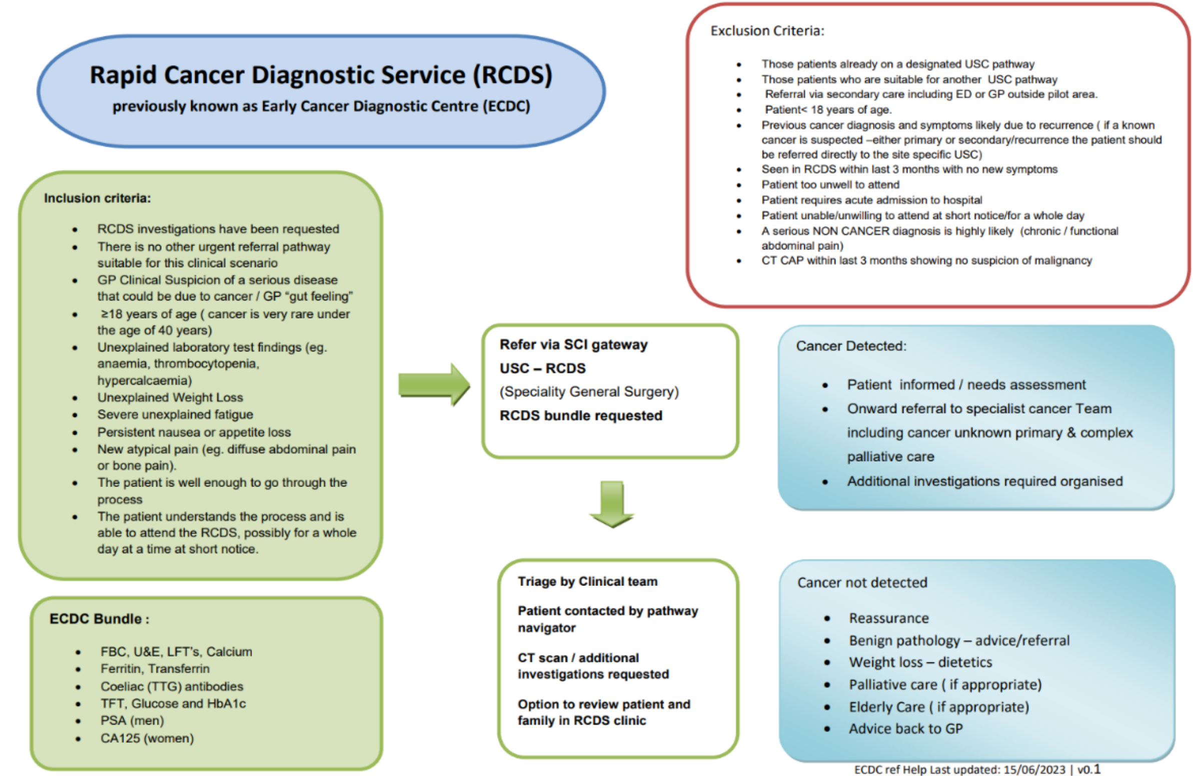
- There may be a need to undertake focus groups with service users/patients to gain more in-depth feedback on how the service could be improved.
- Given the longest delays within the pathway were experienced over the Christmas period, actions to better anticipate and mitigate delays during this time of year should be explored so patients are not unfairly disadvantaged.
- More frail patients were often not eligible to undergo the full RCDS pathway; improving the recording of frailty scores prior to referral may support improved triaging of patients, and/or or be integrated into the eligibility criteria for RCDS.
- Improvements in experience/functioning of Near Me required given potential to be a promising solution for remote consultations.

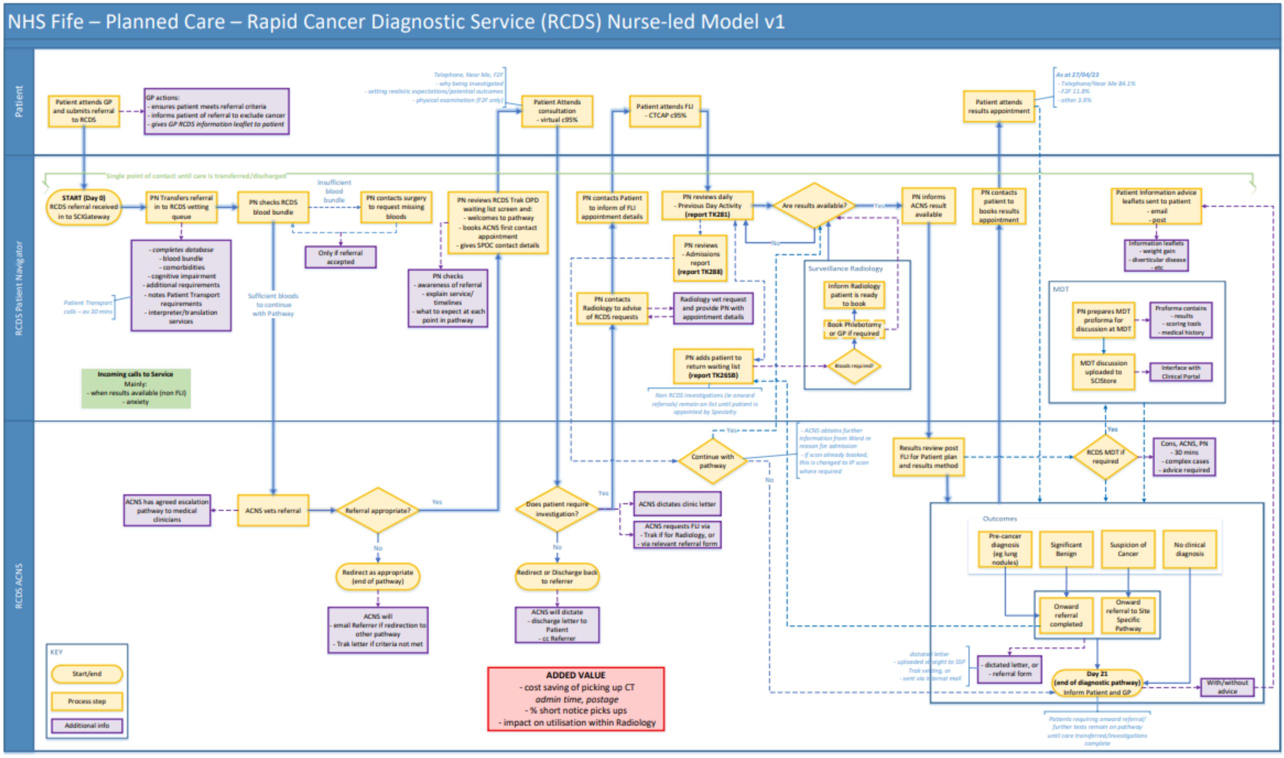
10. Future analysis

- A streamlined national dataset will be agreed and collected by Public Health Scotland. This will improve consistency of recording within RCDS datasets to enable easier analysis.
- Continue to monitor the effectiveness of the pathway over time. Benchmark performance of RCDS against 31 and 62 days waiting time standards. Investigate causes of delays and record consistently e.g., Christmas post, follow-up investigations, patient-induced delays.
- Explore differences in DNA rates between RDCS and USC pathways, and reasons behind these, to inform learning on how to improve access to services.
- Compare differences in timeline to diagnosis between RCDS and direct access to CT CAP.
- Better understand and analyse the benefits of RCDS to wider services e.g. benefits to radiology in terms of uptake of slots will reduce DNA rates, and RCDS may be successfully diverting unnecessary referrals and investigations by other specialties.
- Evaluate tests of change within RCDS and report findings. Propose reporting on upper GI/hepatobiliary this autumn, and colorectal in spring 2024 (lifestyle medicine intervention introduced after period of analysis for this report).
- Undertake more in-depth analysis of symptom profile of patients being referred to RCDS, examining differences between those eligible for referral and those re-directed. This could support tailoring of future eligibility criteria.

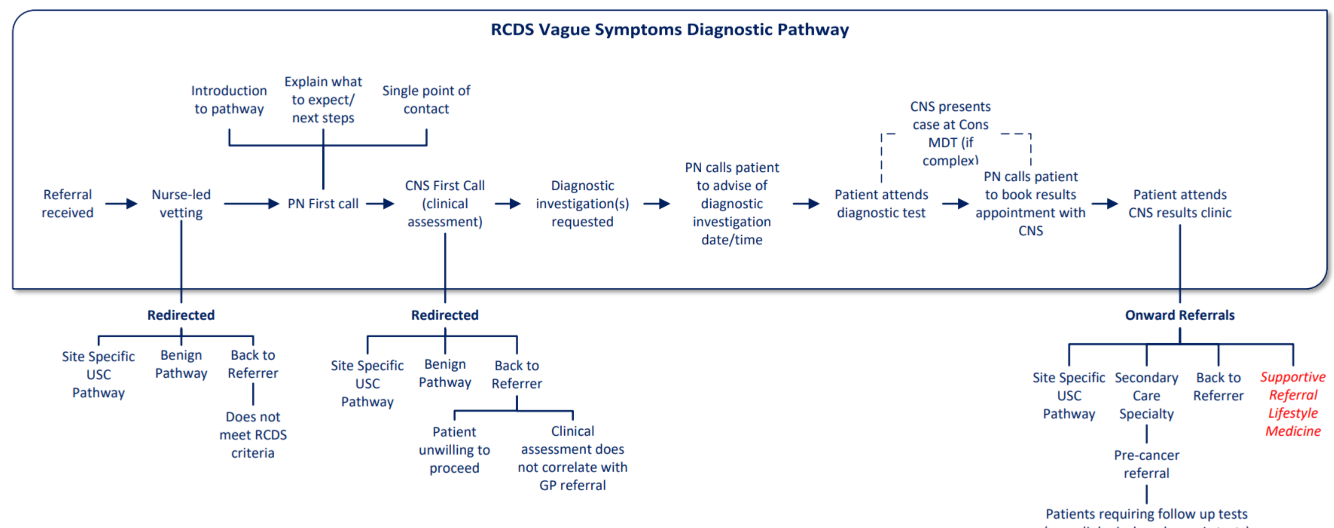
- Identify opportunities for research to enable wider sharing of lessons and contributing to the evidence-base e.g. on the cost-effectiveness of patient navigators.
- It could be useful to compare the effectiveness of the RCDS with current Cancer of Unknown Primary pathways, where patients also tend to present with vague and indeterminate symptoms. The RCDS may provide these patients with a more effective pathway.

Appendix 1 Diagram of Rapid Cancer Diagnostic Service





Appendix 2: Pathway



Appendix 3: Case Studies

Four Case Study Vignette

Patient with bone metastases
Presented with worsening back pain to their GP. At the time of presentation, they did not meet the requirements for an urgent MRI.

Fast forward a month or two, this same patient represents with symptoms now meeting the criteria for an urgent MRI, and this MRI returns with findings of secondary spinal bone metastases.

The GP urgently referred this patient to the RCDS, we spoke to the patient the same day, offered CT imaging before the end of that week, and had a biopsy scheduled the week after for histology.

This patient had already been faced with a significantly delayed pathway and, with RCDS, we were able to expedite care, streamlining several appointments to treatment from a single point. This made all the difference to this patient and their journey.

Patient with Lymphoma
Presents with vague symptoms of fatigue and appetite loss over a 6/12 period. The GP referred to the RCDS where within a week the patient had a CT scan return with suspicions of abnormal lymph nodes. We know that if there is suspicion of lymphoma, histology is required. We were able to carry out a LN assessment and schedule a LN biopsy for the patient under day surgery, whilst making the haematology team aware of our suspicions so that this patient was flagged for review of pathology and MDT. This allowed us to gather the histology required for transitioning care to haematology, expediting management and treatment for this same patient.

Patient with Giant Cell Arteritis/Renal
Focuses on one of the more interesting benign cases which was also found to have cancer. The patient presents with weight loss, fatigue, and raised inflammatory markers of no clear source. They had their assessment and a CT scan, which returned with evidence of possible large vessel vasculitis and a renal lesion. With the urgency of this suspected rheumatology condition, The RCDS team liaised with on call Rheumatology, who organised a review of the patient the same day and the gentleman was in fact diagnosed with a Giant Cell Arthritis. After this we had already referred him to Urology for MDT discussion and he was found to have a renal cell carcinoma too, for which he has since undergone a nephrectomy.

Patient with Coeliac
The patient presents with nonspecific and generalised abdominal pain, weight loss and fatigue. This gentleman had not had his full bundle completed at point of assessment, and this was delayed in being completed. The patient's scan was reassuring, with no abnormalities, or cause for his symptoms identified. As there was a delay in his bloods, we had to follow up with this patient a second time. When his bloods returned, they indicated he had a new diagnosis of coeliac disease. With this case, you can see the importance of completing the full referral screen, so that we can be complete with our patient assessment and care. We gave the patient the news, provided him access to the specialist dietician and coeliac pathway, and he received support and education of his new condition the same week from the dietetic team.
This offers some insight into the breadth of conditions and illnesses encountered within the service, and the obvious benefit the RCDS offers for these patients. These examples show this can streamline care for these individuals, while supporting primary care service too.

Appendix 4: Examples of stories from Care Opinion on the RCDS

"I was amazed at the speed of the service, but also the seriously ability of the ECDC (Early Cancer Diagnostic Centre) team to arrange follow up with the necessary specialties. When I received an unexpected appointment and phoned you, I could not have been treated with more courtesy, and you immediately arranged for Katie to contact me. When She spoke to me on the phone she was willing to answer any questions I asked but what struck me, was that she was also willing to spend time trying to put me at ease."

"I cannot speak highly enough of the experience, and please accept that I have nothing negative to say about it, but as an aside, it might be helpful for you to know, that a letter from the service dated 23rd December 2021 did not arrive until 10th January 2022! Whether it was held up in internal mail due to Christmas and New Year, or external mail for the same reasons, we will never know, but it reminds us that even with the very best of systems we are sometimes dealing with things beyond our control! It in no way detracted from a seriously exceptional and excellent service."

"My 88 year old mum has been losing weight for some time now. Recently her GP referred her to the ECDC. As you can imagine, the mere mention of the word "cancer" sparked alarm and concern in my mum and me. But our Pathway Navigator Lorna explained that a referral to this new service doesn't necessarily always mean a cancer diagnosis will follow.

Lorna telephoned my mum to advise that she had arranged CT scan for just a couple of days later on Thursday, and her results were relayed via video link on the following Monday by Nurse Specialist Katie.

Straight away Katie reassured us that nothing "sinister" had been detected on the scan. My mum still has a few issues to be followed up, but Katie will liaise with my mum's GP surgery and other specialist colleagues about the ways forward for those, and will telephone my mum to discuss the outcomes after a meeting this Thursday.

The whole process, from initial referral to scan results, took only a few days. It was reassuringly quick. Additionally, being able to speak to Katie via video link, and to Lorna via telephone and email, really cut down on waiting for letters, etc (Lorna really went out of her way to keep me informed about what the arrangements were at each step of the process, and to explain what to expect).

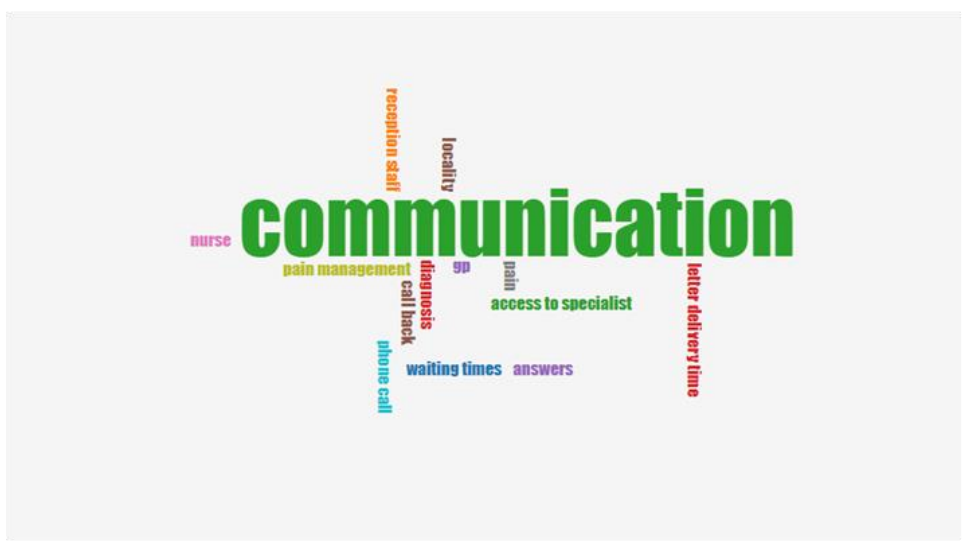
At 88, it's quite an ordeal for my mum to travel to and from hospital, not to mention the difficulties around parking, and is another reason why the approach of this service to distance communication was so welcomed by us.

So, as we write, there are one or two things still outstanding to happen for my mum, but knowing people like Katie and Lorna have them in hand really takes a lot of the stress and anxiety out of the situation. We hear so much about how the NHS is struggling to cope, and I know it may put some people off coming forward for treatment, believing they either will not be seen for ages, or that their concerns are not 'important' enough to burden an already-struggling health service. But this new diagnostic department provides such a fantastic service, which is delivered quickly and efficiently by knowledgeable, patient and empathic staff, that we would encourage anyone to take up any offer of a referral. Both my mum and I (and the rest of the family) are extremely grateful for everything they've done for us. Thank you 🙏"

Appendix 5: Analysis of Care Opinion Feedback (word clouds)

What was good?

What could be improved?



How did you feel?

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NHS Fife

Meeting: **Senior Leadership Team**

Meeting date: **5 September 2023**

Title: **NHS Fife Rapid Cancer Diagnosis report (June 2021- June 2023**

The aim of the RCDS service was to develop a person-centred diagnostic pathways and provide primary care with a new route through which to refer **patients with non-specific symptoms**, such as unexplained weight loss, pain or fatigue that may be suspicious of cancer. The pilot programme was planned to run from June 2021- March 2024.

Roll out of the RCDS model is planned for all health boards by 2025-6 and is a key part of the NHS Scotland cancer strategy (2023). The second waves pilots in Borders and Lanarkshire are currently using our model and training packs to develop their own services.

The Centre for Sustainable Delivery (CfSD) has commissioned the University of Strathclyde to conduct a detailed evaluation of Scotland's RCDS's and an economic evaluation which is due in November 2023. This evaluation will evaluate the cost effectiveness of RCDS model, service benefits and quality-of-life benefits to patients. The comparator models used will be a consultant based model in NHS fife and GP (CT in primary care) model in A&A. This will then inform recommendations for the wider expansion and delivery of the RCDS model across Scotland.

The RCDS was awarded £297,394 (year 1), £282,131 (year 2) and £305,893 (year 3). An addition £167,468 was been agreed by the Scottish government to support the RCDS GI expansion.

RCDS is an award winning innovative model of care. The service has been positively received by patients, GPs, and other healthcare professionals. The fact that the number of referrals to the service has steadily increased since it started reflects greater awareness of the service and the gap it is clearly filling. Most encouragingly, access to the service is shown to be equitable, with data indicating good uptake and low DNA rates by those living in all SIMD quintiles and consistently reaches and diagnoses cancer in those living in more deprived areas.

The pathway also provides a timely service from referral to diagnosis and offers a model of care where patients know when, and how they can get access to the right help, at the right time, in the right place. The attached report supports the positive impact of a nurse-led RCDS on outcomes and patient satisfaction.

The RCDS accepts a range of patients that otherwise might to spread across a variety of specialities and referral types. The RCDS concentrates these referrals in to a single cancer pathway and coordinates their care which would be difficult to replicate within existing resources.

RCDS figures - August 2023:

- 1829 referrals
- 623 referrals not accepted onto pathway 34.1%* (2/3 referred to other cancer pathways, 1/3 back to GP)
- 1206- eligible for pathway 65.9%
- 1127 completed pathway 93.4%
- 11.4% cancer diagnosis (128 cancers)
- Did Not Attend/Could Not Attend (DNA/CNA) rate for test and follow up is <1%
- Referrals by SIMD 1 - 24.8%, SIMD 2 - 21.6%, SIMD 3 - 19.5%, SIMD 4 -18%, SIMD 5 - 16.2%
- 95% patients diagnosed /cancer excluded within 21 days (median 13 days)

** Referrals not accepted on to pathway are categorised as (294 meet an urgent site specific cancer pathway 47.2%, 249 do not meet RCDS criteria 40%, 30 unfit for pathway 4.8%, 19 a serious non cancer diagnosis is highly likely 3%, 14 Criteria for benign pathway 2.2%, 11 Patients unable to proceed 1.8%,6 Seen within last 3 months with no new symptoms 1%*

2.3 Assessment

This part of the paper will look at what is required for a sustainable RCDS service to transition to business as usual and the impact on services if the RCDS did not exist and a decision not to fund was taken

The service requires two CNS and two pathway navigators as a minimum to cover annual leave, sickness and fluctuations in workload. 1.6WTE is taken up by RCDS and 0.4WTE used to cover the upper GI /HPB expansion. 6 months data available on upper GI/HPB expansion is this cohort forms the second commonest group encountered in RCDS behind lung cancer.

The RCDS is sustaining activity and diverts 700 referrals per annum from general surgery. The first 6 months of expansion into the GI cancers has resulted in diverting approximately 400 patients (anticipated 300 OPD new clinic appointments/year).

RCDS is effective in re-direction 2/9 referrals and 1/9 are returned to general practice.
Most referrals are redirected to an appropriate service or site specific cancer pathway. The service is virtual (require's limited OPD space/resources) and can facilitate a discussion with a patient within 24 hours of referral – redirection /referral are based on these discussion. CT scans are actively booked and short notice cancellation in radiology are utilised by RCDS, often the same day. DNA rate in RCDS is 0.5% compared to 4-8% in general surgical USC OPD.

RCDS Costs:

Current Funded RCDS/upper GI model
1.0 WTE Advanced Clinical Nurse Specialist (ACNS) - Band 7
1.0 WTE Advanced Clinical Nurse Specialist – Band 6 (Annex 21 Training)
1.0 WTE Patient Navigator/ Trainer - Band 5
1.0 WTE Patient Navigator –Band 4
0.5 WTE Secretarial Support – Band 3
1.0 WTE GP lead
0.5 WTE Consultant Clinical Lead (plus SPA support)

0.6 Radiology Booking Clerk – Band 3

RCDS staff costs

Grade	WTE	Current pay 2023-4	Number required 24-25	Add 5% estimated pay uplift 24-25
Band 7	1	61035	2	128173.5
Band 6	1	49703		
Band 5	1	39463	1	41436.15
Band 4	1	35919	1	37714.95
Admin & Sec Band 3 20 hrs	0.53	18958	1	19905.9
Consultant	1PA	15966	1	16764.3
GP	1PA	8262	1	8675.1
Total		**£221,323**		**£252,670**

Workforce requirements:

The RCDS workforce is based on the core RCDS workload and the additional RCDS UGI pathway. Although the RCDS initially functioned on a single nurse/pathway navigator with the increase in referrals, annual leave and sickness increase in the model was required to maintain a sustainable service. This additional capacity was able to absorb the Hepato-biliary and upper GI cancer service (Part 1 of GI expansion). This paper costs 2.0WTE. National calculation (RCDS only) will likely be 1.8 WTE.

Radiology Costs

With the increase in referrals seen in Fife the Scottish government funded additional CT sessions. This was necessary to facilitate the rapid turnaround of RCDS CT scan requests within a 14 day window required for a 21days pathway to be met. These costs have been included within this bid to maintain the delivery service at the same level as the Pilot. Admin support (0.6WTE band 3) and a whole day WLI alternate weeks was supported to account for displaced in week work to support the RCDS.

	WTE	Current pay 2023-4	Number required 24-25	Add 5% estimated pay uplift 24-25
Radiology Band 3 admin	0.6	21461	1	22534.05
Radiology WLI 2 clinics/month		35928	24	37724.4
Total radiology costs		**57,389**		**60258.45**

Economic costing vary greatly between NHS boards for NHS Scotland - all probably under estimate the costs of a CT scan (maintenance/replacement/reporting costs) – NHIR costs are £247 / CT scan.

The use of premium time working to facilitate the fast turnaround and reporting of scans is approximately £83 scan. Although some of this costs need to be considered in the context of

increase overall capacity in the service that may be offset to create capacity that is used by the annual increase in demand for CT and the cost benefit of filling short notice cancellations (reduction in DNA rate in CT). Without funding RCDS a proportion of these radiology costs will still exist.

Comparator costs / options

The comparator group in NHS fife would be a return to a consultant based service.
Currently the routine waiting list in general surgery is 2334. Routine new patients are currently waiting over 12 months to be seen in clinic. The addition of 850 USC referrals and 680 follow up patients into OPD would have to displace routine clinic patients (many who have already waited over 12 months). At present the waiting lists is static suggesting current in week capacity meets demand (but this is not sufficient to reduce the current waiting list unless alternative measures are used).

An evaluation of general surgical demand and capacity would suggest that this activity would impact disproportionately on the routine (the longest waiters) patients reducing our capacity to take routine patients off from the waiting list whilst continuing to add new routine patients at the same historical rate (plus 8%). In this way routine patients waiting times are likely to double (patients waiting up to 2 years) without significant mitigation.

Potential mitigation to the general surgical OPD could take the form of increased locally delivered capacity through waiting the times (if consultants available) or externally through (external agency/private sector delivered activity)

Consultant Comparator model: (baseline comparison only)

The consultant comparator model assumes that the RCDS work in brought into normal OPD activity. New OPD costs of £140 per new patient and £100 per follow up. Administration time for vetting and results management have been included (a more detailed evaluation will be available by strathcylde university) Consultant costs assumed for administration and vetting time. Fixed costs for clinics are used . Additional secretarial time included calculated to be minimum 1 WTE and band 3.

RCDS Consultant Model (£250,418) (5% pay award 2024 cost – 274,748)

Vetting time – 10 mins (average) 1140 referrals
Rejection rate 3% (previous consultant performance) – 50 /year (zero cost)
Redirected (RCDS model) 250 (zero cost)
New Clinic Time – x850 - £140/appointment
Administrative time 12 mins per order, result review, dictation ,letter sign off, patient query
Follow up OPD (<50%) – x400 (displace routine work) £100/ appointment
Additional Follow up 150 (£100/appointment)
DNA rate 4% & 8% £120 /appointment lost
Equivalent secretarial time.(1.0WTE) 35770 (band 3)

In reality this comparator does not exist as there is no capacity to provide the service. This is used to compare the RCDs nurse model to previous consultant care model.

Alternative to RCDS (if unfunded)

All alternative options would require a transition period so that clinical & referral pathways could be amended and existing patients within the service transitioned to consultant based care.

Option 1: Do nothing and return to consultant based service (see figure 1)

Both new patient and follow up waits would increase significantly in General Surgery. Routine waits in general surgery outpatients are over 12 months and the likelihood would be these waits would increase further as the service would have to accommodate and prioritise additional USC workload within the existing clinic capacity. (Existing WL (new) is 2334 – an additional 1530 appointments would be required within 12 months).

Option 2 : Waiting list Clinics: (RCDS workload)

1530 clinic slots required (new FU & DNA repeat) WLI costs for displaced work
130 clinics would be required.
Cost WLI (clinic cost, consultant cost, nurse) = £2020

Waiting list clinic has a limited appeal. Given this demand it is unlikely that general surgery would able pick this up additional activity particularly given that over 100 WLI session in endoscopy are already provided by the general surgical team. It is likely only 50% of this activity could be reasonably expected to be met through premium time working.

2024 WLI comparator cost:

WLI clinic costs	£262,600
Administration costs	£ 97,720
Total cost WLI	£360,320

Option 3 : Private sector provision: (backfill displaced OPD workload)

RCDS USC referral would be managed in consultant clinics. Displaced activity from clinic could be given to a private provider. Typically the clinics are 14 patients and £2500/session. 124 clinics required to cover displaced activity

Additional admin and review /verification of patients lists by 3rd sector for surgery would require additional clinics/admin to ensure appropriateness given previous experiences (admin costs additional clinics at WLI rate – frequency 15% patients require in house consultant review additional 20 WLI required £2020) .

Clinical Governance to manage such a large volume of activity displacement to a 3rd sector would need to be in place and discussed with General Surgery and Planned care.

2024 Private sector comparator costs:

Displace clinics (110):	£275,000
Rcds admin costs:	£97,720
Additional WLI/PSadmin:	£45,226
Total RCDS costs:	£417,946

RCDS Upper GI HPB model:

The upper GI and HPB RCDS model is provided within the 2.0WTE RCDS model effectively delivering this service/activity as additional value. This work will not be costed as part of the national RCDS evaluation although the RCDS GI expansion (HPB/upper GI and colorectal) is currently funded through CfSd.

RCDS: Upper GI Consultant Model (£79,054) (5% pay award 2024 cost – £83,006)

- Vetting time 8 mins (15% rejection)(no RCDS available for redirection)
- Straight to test 440
- Additional 75 to STT endoscopy (£18,500 conservative)(vs clinic alternative)
- Clinic new 265, FU 80
- Administrative time 15 mins per order, result review, dictation ,letter sign off, patient query

The services works well with RCDS given the similarity in the clinical pathways and helps justify the increased cost to provide this service - £31,630 (RCDS nursing time). WLI costs to cover OPD activity above is £58,075.

2.3.1 Quality / Patient Care

RCDS has been positively received by patients, GPs, and other healthcare professionals. The fact that the number of referrals to the service has steadily increased since it started reflects greater awareness of it and that it is clearly filling a gap.

Patient feedback has been very favourable in terms of the speed of investigation, prompt delivery of results, reduced stress for both patients and relatives, patient centred approach used and communication.

Most encouragingly, access to the service is equitable, with data indicating good uptake and low DNA rates by those living in all SIMD quintiles. Although the numbers are low, the service is consistently reaching and diagnosing cancer in those living in more deprived areas. The pathway also provides a timely service, with most patients having cancer confirmed or excluded within 21 days.

The ability to deliver similar levels of patient centred care and timeliness in a consultant model without additional administrative or pathway navigator support (not included in comparator model) is highly unlikely.

Initial modelling with Strathclyde University suggest that the pathway would be at least 8 weeks and 150-180 patients would be in the pathway at any one time compared to 30 in RCDS. This would make the tracking and active management of the pathway extremely difficult.

2.3.3 Financial

Model RCDS only	Cost of current service	Cost 2024-25 service	Savings (excl. radiology)
Radiology support	57,389	60,258	
RCDS service total (requested)	278,712	312,878	
RCDS model			
RCDS staff 2WTE RCDS staff 1.8WTE	221,323 200267	**252,620** 220,990	Baseline cost
Consultant model (assume additional capacity available without WLI)	250,418	274,748	**+£22,128**
Consultant model WLI USC (no radiology)	360,320	378,336	**+£125,716**
Consultant model Outsourced activity	417,946	438,854	**+£186,236**

Additional future staffing costs:
RCDS staff costs at top of scale – 2029-2030 estimated to be £334,947 plus potential pay awards. NHS consultant staff pay could potentially could rise significantly given indication to restore pay parity to 2009 levels(30-40%).

Financial comparison:

The RCDS nursing model offers a high quality, patient centred approach, the value of this is not calculated in this paper but will be discussed in the Strathclyde University evaluation of the RCDS. Higher quality usually comes with an incremental cost.

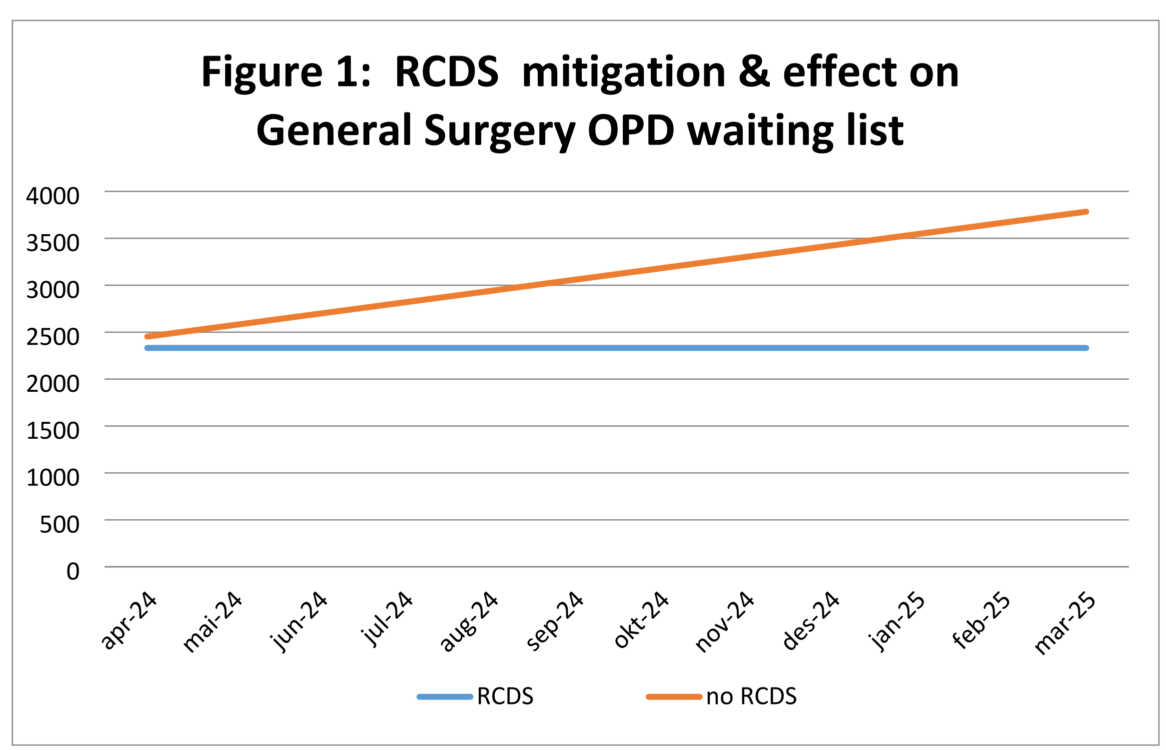
There currently is insufficient capacity within general surgery to meet current demand let alone absorb the RCDS workload (current routine OPD waits are over 12 months). This paper discusses the potential mitigation required to offset the RCDS model if the service is **not funded**.

Currently the RCDS staff model is approximately £22,128 cheaper than the estimated consultant service comparator model. The RDS does require an additional £60,258 to support l premium time CT slots (baseline radiology for non premium time CT scans is approximately £177,840 for context). There is also no guarantee the radiology costs within this model would return to zero as the radiology requirements would not disappear and additional premium time working may still be required to maintain current cancer waiting times.

The alternative strategies of WLI or Private sector provision for RCDS or displaced routine workload both add significant cost over the RCDs model. (£125,000-186,000 more expensive). Additional management time would also be required to run these models which not included.

A 2.0WTE nursing PN model is used as this mirror's the current service. The current RCDS service is also able to provide the upper GI and HPB pathways no additional cost (valued at £83,000)

Based on the WLI comparator model (assuming a significant rise in OPD waits is to be avoided) then the RCDS can be delivered with the additional radiology costs and the Upper GI and HPB cancer pathway for a saving of £65,458 (17% cost saving)(28% over private sector costs).



Funding alternatives:

Currently the service is funded through CfsD. CfSd are looking to take a funding proposal to Ministers after the Strathclyde report is published to look at proposals to fund existing RCDS pilots up to and after national roll out. The second phase pilots have funding to the end September 2024 but we are not included in this as limited funds exist within CfSd.

Cancer waiting times and 'waiting times' money would be alternative funding strategies as both mitigations for not continuing with the RCDS service would require either private sector or WLI activity to maintain the current waiting list.

RCDS would be a more cost effective way to provide this activity were this approach to be taken.

Staff redeployment and service transition:

Planned care would have to give notice or an indication that the service was not going to continue in order to allow staff to make alternative enquires or arrangement. Funding is up to end of March 2023. We would seek a realistic timescale on a decision prior to this (a 3 month notice would normally be expected.) 2-6 months would be required to discontinue the service depending on the complexities involved.

An independent RCDS costing model is being worked up by Strathclyde University and is expected to be available by end November 2023.

2.3.4 Risk Assessment / Management

All Boards were commissioned to develop an Annual Delivery Plan (ADP) to drive forward change across health and social care within NHS Fife within the context of a challenging financial situation. RCDS has a green rating applied as the purpose of the model was to ascertain the feasibility of this model

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

An assessment on the impact on health inequalities has been embedded within the Cancer Framework 2022-25 and in each monthly report to the project steering group, with regular reports to the Acute Cancer Service Delivery Group and the Cancer Governance and Strategy Group to assure, through cancer governance, there is a focus on this through the pilot programme.

2.3.6 Climate Emergency & Sustainability Impact

The policy commitment already exists in regards to introducing RCDS pathways across NHS Scotland, to ensure equitable access (A Fairer, Greener Scotland: Programme for Government 2021-22). RCDS supports the NHS Scotland Climate Emergency & Sustainability Strategy 2022-26) by delivering personalised care utilising patient navigators practise shared decision making and tackle unwarranted variation in health, treatment and outcomes, therefore contributes to reduce harm and waste and deliver better value care – better value for patients and for our health and care system. The Scottish Government aims to reduce the number of kilometres travelled by car in Scotland and as RCDS is primarily a telephone led service we can influence patient and visitor travel because historically the patient would have to attend hospital visit 3 times (See Consultant at Clinic, attend for investigation, attend clinic again to receive results) to date 98% of our patients only attended for their investigation appointment.

2.3.7 Communication, involvement, engagement and consultation

This paper has been circulated for comment to:

- Associate Director of Quality and Clinical Governance
- Cancer Leadership Team
- RCDS Clinical Team
- Planned Care – General Manager
- RCDS Project Group

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

- Associate Director of Quality and Clinical Governance
- Planned Care Directorate General Manager, 24/08/23
- Cancer Leadership Team 29/08/23

2.3.9 Additional benefits:

The RCDs can support alternative strategies within NHS Fife:

- Development of a colorectal RCDs and an Optimal Colorectal Cancer Pathway.
- Allow other specialities to adopt similar service principles
- Facilitate medical student, GP trainee and ANP teaching,

In addition this service can be used as a teaching resource for St Andrews Medical School to facilitate Cancer Pathway Teaching to ScotGem students. If funding is successful a pilot SSM is anticipated in 2024

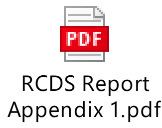
2.4 Recommendation

- Discussion – for examining and considering the of the attached detailed summary summarising the activity and developments within RCDS over the last two years.
-
- Decision- The board reach a conclusion on funding this service after March 2024.

3 List of appendices

The following appendices are included with this report:

- Appendix No.1-NHS Fife Rapid Cancer Diagnostic Service Report (June 2021-June 2023)



RCDS Report
Appendix 1.pdf

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NHS Fife

Meeting:	**Senior Leadership Team**
Meeting date:	**21st May 2024**
Title:	**RCDS – General Surgery GI USC Test of Change Report (January 2023-January 2024)**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Murdina MacDonald, Lead Cancer Nurse** **Mr Neil Cruickshank, Consultant Colorectal Surgeon**

1 Purpose

This report is presented for:
- Discussion

This report relates to:
- Annual Delivery Plan
- Government policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- NHS Board / IJB Strategy or Direction / Plan for Fife

This report aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The attached report (Appendix 1) provides a comprehensive report on the activity and outcomes of our Rapid Cancer Diagnostic Service (RCDS) Upper GI Urgent Suspicion of Cancer Test of Change (ToC) initiative reported from January 2023 to January 2024. This report aims to inform stakeholders of the progress, impact, and lessons learned from the Upper GI (ToC) model.

2.2 Background

The test of change was implemented to improve the patient diagnostic pathway. It involved a multidisciplinary approach, including the introduction of a nurse-led vetting and training program, to streamline processes and enhance patient care. Key metrics and outcomes were tracked throughout the year to assess the effectiveness and scalability of the model.

2.3 Assessment

The Rapid Cancer Diagnostic Service (RCDS) conducted a test of change aimed at expanding their current RCDS principles and nurse-led model into two gastrointestinal (GI) cancer pathways. The objective was to implement a nurse-led model for vetting, triage, and assessments, providing patients with a single point of contact within the service. This approach was designed to promote timelier and more person-centred care for patients on these urgent suspicion of cancer (USC) diagnostic pathways.

Data Collection and Analysis:

Data was collected from patients referred for GI USC investigations from January 9, 2023, to January 31, 2024.

Both qualitative and quantitative data were analysed, including age, gender, SIMD (Scottish Index of Multiple Deprivation), symptoms, and patient experiences.

Key Findings:

During this period, 796 referrals were redirected from consultant vetting time. 157 patients were assessed by the Advanced Clinical Nurse Specialist (A(CNS)) via telephone or face-to-face clinic appointments. 41 cancers were diagnosed during this period, alongside a variety of pre-cancerous conditions such as Barrett's oesophagus and intraductal papillary mucinous neoplasms (IPMNs). There was a 0% Did Not Attend (DNA) rate for nurse-led clinics and radiology appointments. Radiology departments confirmed the added value and sustainability of the nurse-led model. SIMD data indicated that the model effectively targeted health inequalities and met diagnostic needs across all quintiles.

Operational and Educational Impact:

The RCDS managed the change without incurring additional costs. Patients reported valuing the personalised diagnostic pathways and felt well-informed and supported throughout the process. The initiative fostered a learning and developmental environment for both Patient Navigators (PN) and A(CNS), promoting resilience and leadership at all levels. PN's maintained a proactive approach to their responsibilities, handling their workload efficiently and ensuring streamlined patient care. The nurse-led model proved valuable and sustainable, allowing the A(CNS) to operate at the top of their license by redirecting non-clinical and lower-complexity cases. The initiative successfully released consultant surgeons' time, enabling them to focus on more complex diagnoses.

Patients were provided with a single point of contact, enhancing their experience, and ensuring they felt well-informed and supported throughout their diagnostic journey. The nurse-led model facilitated timely and person-centred care, addressing individual patient needs effectively. The A(CNS) conducted thorough clinical assessments via telephone or face-to-face clinic appointments, ensuring that all relevant information was gathered efficiently.

The test of change demonstrated the ability to manage the initiative without incurring additional costs, optimising existing resources effectively. The nurse-led model allowed for better allocation of time and expertise, particularly by freeing up consultant surgeons to focus on more complex cases.

The initiative achieved a 0% Did Not Attend (DNA) rate for nurse-led clinics and radiology appointments, indicating high engagement and adherence to scheduled appointments. SIMD data revealed that the model effectively targeted health inequalities, ensuring that diagnostic services were accessible and equitable across different socioeconomic groups.

The success in reducing DNA rates and increasing consultant capacity underscores the value-based aspect of the model, demonstrating its potential for cost-effective and efficient healthcare delivery.

The model's scalability and applicability to other diagnostic pathways highlight its value for future workforce planning and broader implementation within the healthcare setting.

This assessment highlights the test of change's impact on quality patient care and value-based care, providing a comprehensive overview of its successes and broader implications.

The change supported timely cancer diagnoses, personalised care pathways, and targeted health inequalities. The model demonstrated scalability and potential for implementation in other diagnostic pathways, highlighting its value for future workforce planning.

Effective interagency communication and support were key facilitators of this change, demonstrating the potential for broader application within the healthcare setting.

This detailed assessment clearly communicates the impact and potential of the nurse-led model within the RCDS, providing a solid foundation for recommendations and future planning.

2.3.1 Quality, Patient and Value-Based Health & Care

During the test of change, we actively encouraged patient feedback about their experience with the nurse-led model. The responses were overwhelmingly positive, highlighting the clarity, support, and personalised care provided throughout their diagnostic journey. Here is a couple of examples of the qualitative feedback: -

Patient A (Non-Cancer): "I was very pleased with the service and found it beneficial when going through a hard time. I spoke with both Trish and Katie. I really appreciated being able to talk to someone when required."

Patient B (Cancer): "I think it is a really good thing. It was helpful being able to contact someone when I ran into difficulty with my new cancer diagnosis. I think it should continue and keep going for sure. I felt well supported throughout."

Feedback from clinical leads of OG and HPB pathways was also positive, emphasising the efficiency and improved patient care resulting from the nurse-led involvement:

Overall, the test of change has been well received by all relevant stakeholders and has shown significant improvements in patient care and management, despite facing some challenges. This initiative aligns with our commitment to quality, person-centred, and value-based care, demonstrating that the nurse-led model can enhance the diagnostic pathway and improve patient experiences.

2.3.2 Workforce

Current Funded RCDS/upper GI model
1.0 WTE Advanced Clinical Nurse Specialist (ACNS) - Band 7
1.0 WTE Advanced Clinical Nurse Specialist – Band 6 (Annex 21 Training)
1.0 WTE Patient Navigator/ Trainer - Band 5
1.0 WTE Patient Navigator – Band 4
0.5 WTE Secretarial Support – Band 3
1.0 WTE GP lead
0.5 WTE Consultant Clinical Lead (plus SPA support)
0.6 Radiology Booking Clerk – Band 3

The initiative led to the diagnosis of 41 cancers and various pre-cancerous conditions, demonstrating the effectiveness of the nurse-led assessments in early detection. By redirecting 796 referrals from consultant vetting time, the model allowed consultants to dedicate their efforts to complex cases, thereby improving the overall efficiency and effectiveness of the diagnostic pathway. Radiology departments provided positive feedback, reinforcing the added value and sustainability of the nurse-led model in the diagnostic process.

Effective interagency communication and support were critical to the success of this change in maximising the value of healthcare resources.

2.3.3 Financial

A recent RCDS report (MacDonald and Maini, 2023) demonstrated the RCDS nurse-led costings when compared to the consultant led model.

The RCDS managed the test of change without incurring additional costs. The initiative was able to utilise existing resources efficiently, avoiding the need for additional financial investment.

The nurse-led model for vetting, triage, and assessments optimised resource allocation, allowing the ACNS to handle initial assessments and redirecting lower-complexity cases from consultant surgeons. This model resulted in significant savings on consultant time.

2.3.4 Risk Assessment / Management

All Boards were commissioned to develop an Annual Delivery Plan (ADP) to drive forward change across health and social care within NHS Fife within the context of a challenging financial situation. This ToC, which is part of the RCDS service, has a green rating applied as the purpose of the model was to ascertain the feasibility of this model.

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

An assessment on the impact on health inequalities has been embedded within the Cancer Framework 2022-25 and in each monthly report to the project steering group, with regular reports to the Acute Cancer Service Delivery Group and the Cancer Governance and Strategy Group to assure, through cancer governance, there is a focus on this through the pilot programme.

2.3.6 Climate Emergency & Sustainability Impact

The policy commitment already exists regarding introducing RCDS pathways across NHS Scotland, to ensure equitable access (A Fairer, Greener Scotland: Programme for Government 2021-22). RCDS supports the NHS Scotland Climate Emergency & Sustainability Strategy 2022-26) by delivering personalised care utilising patient navigators, practise shared decision making and tackle unwarranted variation in health, treatment and outcomes, therefore contributes to reduce harm and waste and deliver better value care – better value for patients and for our health and care system.

The Scottish Government aims to reduce the number of kilometres travelled by car in Scotland. As RCDS is primarily a telephone/virtual led service we can influence patient and visitor travel as historically the patient would have to attend a hospital visit at least 3 times (see consultant at clinic, attend for investigation, attend clinic again to receive results).

2.3.7 Communication, involvement, engagement and consultation

- This paper has been circulated for comment to:
- Associate Director of Quality and Clinical Governance
- Cancer Leadership Team
- RCDS Clinical Team
- Planned Care – General Manager
- RCDS Project Group

2.3.8 Route to the Meeting

This paper has been previously considered under the auspices of the RCDS report and regular PSR reports to the RCDS project steering group and Cancer Leadership Team and Cancer Governance & Strategy Group:

- Planned Care Directorate General Manager (14/05/24)
- Associated Director for Risk and Professional Standards
- The Cancer Leadership Team (21/05/24)

2.4 Recommendation

This paper is provided to members for:

- **Discussion** – providing a detailed summary of the UGI test of change commencing 09/01/2023.

3 List of appendices

The following appendices are included with this report:

Report Contact
Murdina MacDonald
Lead Cancer Nurse
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Appendix 1
Rapid Cancer Diagnostic Service (RCDS)
GI Cancers *UGI/HPB) Test of Change

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Adverse Events Improvement Plan Update**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Claire Fulton, Adverse Event Lead**

Executive Summary

Adverse Events Improvement Plan provides detail and progress on areas of improvement identified for 2024/2025, broadly these are:

- Reporting;
- Reviewing;
- Learning and improving from adverse events; and
- Improving support and engagement of patient/families and staff with the process.

Adverse Events Trigger List has been updated to align with Healthcare Improvement Scotland, Reporting and Learning from Adverse Events – A National Framework

The proposal to implement the refreshed trigger list from 6th January 2025 was accepted at Clinical Governance Oversight Group on 22nd October 2024

There are two key changes that have emerged from the agreed update to the Adverse Events Trigger List, these are:

- Type of events triggering major and extreme harm
- Review and learning from events which are proposed not to trigger major/ extreme

Process changes to ensure that the above-mentioned events have a robust review and governance process in place, as detailed in the improvement plan, were agreed at Clinical Governance Oversight Group on 22nd October 2024

An updated paper will return to Clinical Governance Oversight Group in December 2024 to finalise and agree the process changes ahead of the implementation date for the trigger list on 6th January 2025

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The review and learning from adverse events is a fundamental component of improving quality and safety. The paper provides an update on the progress of the adverse events improvement work. The improvement plan 2024/2025 (appendix 1) details improvements to process in the areas of:

- Reporting;
- Reviewing;
- Learning and improving from adverse events; and
- Improving support and engagement of patient/families and staff with the process.

The purpose of this paper is to inform the Clinical Governance Committee of the changes to the adverse events clinical trigger list as a result of collaborative working across directorates and specialties. Details of which can be found in sections 1.7 and 1.8 of the improvement plan (appendix 1).

2.2 Background

The trigger list (appendix 2), aligned to the HIS national framework, bases triggers for reporting of major and extreme events only on outcomes in terms of harm experience by the affect person (patient or staff member).

2.3 Assessment

There are two key changes that have emerged from the agreed update to the Adverse Events Trigger List:

1. Type of events triggering major and extreme harm
2. Review and learning from events which are proposed not to trigger major/ extreme

Types of Event Triggering Major and Extreme Harm (appendix 3)

The first is the 'event type' where the outcome in terms of *harm* will trigger reporting as major/extreme harm (i.e. unexpected death). The HIS framework requires that cardiac arrest, Sudden unexpected death of and infant (SUDI) and drug and alcohol deaths are reported as major or extreme.

In NHS Fife, cardiac arrests, have always been reported as major harm, however SUDI and drug and alcohol deaths have not always been reported this way.

These event types may have been reported as moderate or less particularly when the link between healthcare delivery the outcome for the patient is weak or unknown from the outset. This has meant that the significant adverse event review (SAER) process was not always activated.

There is currently a cluster review process for cardiac arrests and drug and alcohol deaths. This presents the benefit to learn from thematics and carries a lesser level of resource burden than reviewing all events through individual SAERs.

It was agreed at the Clinical Governance Oversight Group (CGOG) on 16th April 2024 that community suicide deaths are managed in a similar manner with the creation of a suicide cluster review process.

The improvement plan details changes which offer a consistent robust structure for review where levels of harm trigger major/extreme outcomes. In summary for cardiac arrest, SUDI's, community suicides and drug and alcohol related deaths the following will be implemented:

- A robust cluster review and learning process with clear routes of escalation for consideration of a SAER where all learning has not been identified or when key issues identified are significant and related to wider organisational systems issues, for each of these areas is to be developed.
- Review outcome coding with rational should be added to current review templates to indicate the findings of the review in relation to the link between care delivery and outcome. When an event has review outcome 4 (*"A different plan and or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm")* as per current SAER process, an improvement plan will be submitted to the SAER executive panel for oversight and monitoring.

Review and Learning

The second change is related to the reviewing and learning process for events previously reported as major harm that will now in line with the HIS framework be reported as moderate or less. There is still a requirement that these event types still have a have a robust process of review and evidence of learning. The improvement plan describes the changes required to ensure these event types continue to have a robust process of review with the addition of governance around learning and actions. The governance structure for the E-Coli CAUTI process that is well established and could be adapted for use for other event types that will follow the Complex Care Review (CCR) process. Once all the governance processes are described, a flowchart similar to that for SAER's will be devised and included in the adverse events policy refresh.

<u>Recommendations</u>

Clinical Governance Committee is asked to note and take assurance from:

- The revised adverse event trigger list and its planned implementation from 6th January 2025.

- The comprehensive adverse events action plan.
- The ongoing oversight of the Adverse Events policy by the Clinical Governance Oversight group.
- The executive leadership of all aspects of adverse events management

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

Fundamentally this is about ensuring that our response to when things go wrong is focused on learning, and resources are applied where the greatest opportunity to learn and improve the quality of care is identified.

2.3.2 Workforce

The improvement journey planned for adverse events will provide staff with knowledge and tools to support judgments and decision making on levels of harm that will be consistent across the organisation.

2.3.3 Financial

It is estimated by the Scottish Perinatal, SAER Group that a SAER requires 24 hours of input by the lead review and 9 hrs for each of the review panel member. In addition to this there is dedicated time required form senior management and executive team representative to review and approve reports. Standardising and creating efficiencies in the adverse events process will reduce the resource burden on the organisation.

2.3.4 Risk Assessment / Management

There is a risk that learning is not being identified and acted on timely, with a significant number of major/extreme outcome in terms of harm event reviews exceeding the 90 day expected completion time and governance surrounding action planning and monitoring lacking.

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
Senior clinical and managerial staff from both acute and HSPC were invited to attend 1 of 2 workshops to engage in discussion on what was required to update the current trigger list. Following agreement on the trigger list this additional bespoke session have been held with key stakeholders to discuss the process for specific event type reviews and the governance of these reviews.

Workshop attendance

Job title	Head of Nursing - Planned Care
Lead for Adverse Events	Senior Nurse - Risk Management and Quality - ECD
Clinical Effectiveness Manager	Child and Young Person's Death Coordinator
Transfusion Practitioner for NHS Fife	Director of Nursing - Corporate
Inpatient Clinical Midwifery Manager	General Manager - Planned Care
Consultant Anaesthetist	Consultant Nephrologists
Child and Young Person's Death Coordinator	Associate Director of Nursing - HSCP
Clinical Midwifery Manager Outpatients and Community	Clinical Director - Complex & Critical Care (HSCP)
Deteriorating Patient/Resuscitation Lead PPD	Head of Nursing - HSCP
Head of Patient Experience	Head of Nursing - Complex & Critical Care (HSCP)
Associate Medical Director WC & CS	Head of Nursing - Primary & Preventative Care (HSCP)
General Manager Emergency Care	Head of Quality, Clinical & Care Governance (HSCP)
Associate Medical Director for ECD & PC	Clinical Services Manager - Community Care Services
Head of Community Care Services (HSCP)	Clinical Service Manager - Community Care Services
Deputy Medical Director (HSCP)	Lead Pharmacist

2.3.8 Route to the Meeting
A variant of 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.

- Update to paper presented to Clinical Governance Oversight Group, April 2024, titled Adverse Events Trigger List
- Clinical Governance Oversight Group, 22nd October 2024

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a **“moderate”** Level of Assurance.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Fife Adverse Events Improvement Plan 2024/2025
- Appendix No. 2, NHS Fife Clinical Trigger for Major/extreme outcomes
- Appendix No 3, NHS Fife, Major/extreme management flowchart
- Appendix No. 4, E-coli CAUTI CCR governance process

Report Contact
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Adverse Events Improvements **Appendix 1**
Work plan 2024-2025

Complete	On track	Not started	Paused

	Improvement (by categories)	Summary	Objective/ Outcome	Owner	Target Date	Progress/status	Agreed/not agreed where relevant
1	**Adverse Event (AE) process**						
1.1	Datix forms DF1 (reported form)	Improvement project to reduced time taken to report AE's	Easily accessible and efficient reporting of adverse events	Datix admin	31/08/24	Changed completed. Average time continues to be tracked. Early indication show reduction in time by 60-90 mins	
1.1.1	Reporting of unexpected deaths	Understand process for death notifications being received by board and identify process where adverse event reporting is required (i.e. within 30 days of discharge following acute admission)	Improve reporting of events that meet criteria	CF	31/12/24	Collaborative work with health records colleagues	
1.2	DF2 (reviewer form)	Refresh and simplify form to be methodical, user friendly and focused on learning	Every adverse event is regarded as a opportunity to learn	Datix Admin	31/12/24	Work of datix team focused on Inphase migration	
1.3	Review of adverse events category – other clinical events	Other category has events that frequently are reported as major/extreme. Regrouping of the subcategories (28) to create additional smaller groups of overall categories	Increase visibility and opportunity to identify themes from all event types	CF	31/03/25	Work will require collaboration with clinical teams. Presented at CGOG in August 24. To return as a full proposal of change in Dec 24	
1.4	Incident management system	Engage with process and provide relevant expertise to	Enhanced system for managing adverse events	SAS	Feb 25	Board Inphase demo May 24. SAS will present update and paper to CGOG 22/10/24	

	(InPhase/Datix)	contribute to board decision on which system to procure.					
1.5	Trigger list	Redefine local trigger list for major/extreme events to align with national framework	Efficient standardised process	CF	22/10/24	Workshops and additional bespoke sessions completed. Final draft of trigger list for agreement at CGOG 22/10/24. Dates updated to reflect delay	
1.6	Report templates For major incidents	Review SBAR, Scope, SAER and learn summary templates and update where necessary to fit with new process evolving from trigger list refresh	Efficient standardised process	CF/CR	10/12/24	Participating in national workshops to co-produce a national standard template for SAER and learn summary. Update local SAER template where relevant whilst awaiting national template	
1.7	Devise guidance for event types specific review were the trigger is major and review (Cardiac Arrest, SUDI, Suicide cluster, Addictions Cluster)	Clearly define all review types that could be commissioned for major/extreme events and understand the governance/assurance process for each	Consistent reviews that are tailored to meet the needs of the specific event type.	CF	10/12/24	Current review types mapped out. Collaboration with leads for the reviews is required to fully map out the process for each review type. Suite of reviews to be presented and agreed at CGOG Dec 24	
1.7.1	Cardiac Arrest (CRP) Review	TOR and/or process map which details governance/assurance route for reviews and monitoring of actions	Consistent robust review of major/extreme events	EM	10/12/24		

		Review template to include outcome coding and escalation					
1.7.2	SUDI	TOR and/or process map which details governance/assurance route for reviews and monitoring of actions Review template to include outcome coding and escalation	Consistent robust review of major/extreme events	LC/AR	10/12/24		
1.7.3	Suicide Cluster Review	TOR and/or process map which details governance/assurance route for reviews and monitoring of actions Review template to include outcome coding and escalation	Consistent robust review of major/extreme events	TL	10/12/24		
1.7.4	Addictions – Drug and Alcohol Deaths Cluster Review	TOR and/or process map which details governance/assurance route for reviews and monitoring of actions Review template to include outcome coding and escalation	Consistent robust review of major/extreme events	TL	10/12/24		

1.8	Complex care review (CCR) templates	Define in the trigger list. Adverse event types where there is organisational focus and moderate harm will have a bespoke CCR completed.	Efficient standardised process. Easier identification of themes and trends from specific event types.	CF	31/08/24	Events for CCR defined as Falls, Tissue Viability, SABS, EColi CAUTI, maternity/neonatal specific as outlined in HIS, Perinatal Adverse Event Process guidance	
1.8.1	Falls	Process map CCR Review Template Governance/assurance route Escalation	Creating opportunity to learn from all level of events and allowing focus improvement work from themes	NB	10/12/24		
1.8.2	Tissue viability	Process map CCR Review Template Governance/assurance route Escalation	Creating opportunity to learn from all level of events and allowing focus improvement work from themes	LB	10/12/24	Leads identified Sept 24, work will be coordinated through the TV steering group	
1.8.3	SABS	Process map CCR Review Template Governance/assurance route Escalation	Creating opportunity to learn from all level of events and allowing focus improvement work from themes	KM/JC	10/12/24	CF to discuss further with leads	
1.8.4	E-coli CAUTI	Process map CCR Review Template	Creating opportunity to	SA/KM /CF	12/2024	Process agreed Dec 2022 at CGOG	Agreed

		Governance/assurance route Escalation	learn from all level of events and allowing focus improvement work from themes				
1.8.5	Perinatal Adverse Events	Process map CCR Review Template Governance/assurance route Escalation	Creating opportunity to learn from all level of events and allowing focus improvement work from themes	AL/CF	2021	Well define process, described in local AE policy. Embedded since September 2021 in line with HIS guidance.	Agreed
1.9	SAER Panel	Review function of group and refresh TOR to reflect this.	Consistent high quality SAER reports. Identification of themes and trends	CF/GC	10/12/24	New process will impact on the function of the panel. TOR requires to be updated prior to new trigger list.	
1.10	SAER Sponsor	SAER sponsor reintroduced in Oct 2023. Role descriptor issued. Initial meeting with sponsors and MD. Systems thinking session	Efficient standardised process. Support for review teams	CF/CR	31/01/24	Process will require continual monitoring to ensure sponsors (10 individuals) are not overburden with variation in number of SAER's commissioned	
1.11	Improvement plans	Compliance with submission of improvement plans within 30days of SAER sign off is variable. Alter process to bring improvement plans back to SAER panel	Closing the loop of learning from SAERs		01/08/24	Initial focus will be on SAER review outcomes graded as 4 (preventable events)	
1.12	Human factors	Increase knowledge and use of human factors tools in reviews	Systems focus approach to	CF	31/07/24	Collaborative work with pharmacy and AU1 using human factors observation of practice and walk	

			understanding and learning			through/talk through tools May24. Observation of practice complete and report provided. Embedding human factors practice will continue in education and training for safety learning reviewers (NES)	
2.	**AE policy and governance**						
2.1	Refresh of policy	Required to reflect updated processes	Standardised and supported approach to adverse events management	CF	Feb 25		
2.2	IPQR	Refresh IPQR content and layout for adverse events	Provide assurance on all aspects of SAER process predominantly focusing on learning and improvement as outcomes and measures appose to timescale targets	GC/CF	10/12/24	Draft proposal with MD for discussion and agreement	
3	**Learning from AE**						
3.1	Preventable events (review outcome 4)	Focus on SAER learning where event is identified as having been preventable. Improvement plans will be approved and monitored by SAER Panel	Leaning from preventable events		31/12/24	SAER's signed off with review outcome 4 from August 24 will be monitored on the new process.	
3.2	Improvement planning and actions from SAER's	Improve oversight and compliance with actions closed on time	Learning from adverse events	CF Datix admin	31/12/23	Bimonthly report to service SLT's listing all open and overdue actions	

3.3	Improvement planning and actions from SAER's	Request review and refresh where needed of local governance processes in place to provide assurance on management and learning from SAER actions	Assurance of learning from SAER's	CMcK/ GC	10/12/24		
3.4	Learning from Adverse Events	Focused improvement work that spans the creation, recording, monitoring/compliance and evidence of learning from actions	Assurance and evidence of an learning organisation	CF	31/12/25		
3.5	Themes and trends	Analyse data from all level of severity of harm events to identify emerging issues and trends over time.	Learning from every AE	CF	28/02/24	Standing item on CGOG agenda	
3.6	Organisation al learning (OL)	OL is on the agenda for every SAER panel. Relevant learning identified will be fed into and discussed at OLG	Creating opportunities to learn	GC/CF	28/02/24	As OLG evolves, process for identifying and feeding in learning may require to be updated.	
4	**Training and Education**						
4.1	SAER sponsors sessions	Bi-annual session chaired by MD	Standardised consistent approach to SAER Peer Support		31/12/24	Session Oct 23 on set up, with MD Bespoke session by NES, Director for Safety, Dec 23 To be arranged session 08/09/24	
4.2	Trigger list/severity grading	Bite size education sessions to be devised and delivered once trigger list agreed	Standardized reported of AE	CF	06/01/25		
4.3	Human factors training	Embed human factors approach into AE review process	Promote a positive safety/learning culture	CF	31/12/25	Links to TURAS, NES Human Factors training added to BLINK Bespoke session requested by theatre. Will be delivered in June 24	

						NES pilot Safety learning review training due to start Nov 2024. 4 nominees to be identified. CF to discuss	
4.4	Adverse Events resource pack	Explore best platform to host information	Easily accessible materials to support review teams		31/08/25	Information started to be added to BLINK. Further work needed as page is difficult to navigate . CF to link with comms colleagues	
5	**Staff support following an AE**						
5.1	Staff support pathway	Pathway includes managers pack, staff leaflet, tools – hot/cold debrief guidance and templates	Valuing staff		31/12/24	Pathway pilot ended Dec 23. Additional bespoke training sessions in AU1 in progress. Next steps Board support and endorsement Scale up and spread of pathway (next 3 areas identified) Educational materials devised	
6	**Patient/family involvement**						
6.1	Service to identify key contact for major/extreme incidents	Update to SBAR to include key contact. This will be recorded on datix and visible through linked record for patient's relations officer.	Transparent process that values patient/families input	CF/CR	22/12/24	Updated SBAR will go out to services along with SAER information leaflet. 01/10/24 SAER patient/family leaflet updated, Key contact role descriptor and 7 step guidance developed and shared with Directors of Nursing. Final draft of documents with DN's for agreement	
6.2	Increase opportunities for patient/family to engage	National framework update will be providing guidance and tools for boards	Transparent process that values patient/families input	SM/CF / LC	31/12/25	Engaging with workshops to shape national framework. Collaborative work with Head of Patient Experience to devise and	

	with SAER process					deliver education on engaging patients/families in learning opportunities (AE or Complaints) .	

DRAFT NHS Fife. Adverse Events trigger list 2024 (Clinical Events) **Appendix 2**

- All never events require to be reported as extreme and have a Significant Adverse Event Review (SAER)
- Outcome in terms of harm should be assessed for each adverse event using the national framework descriptors below as a guide. Further details can be found in NHS Fife Adverse Events Policy here
- All events that have extreme or major outcome in terms of harm on the trigger list require to have an SBAR completed and submitted to Fife Adverse Events as per the directorate process where the event occurred. Unless otherwise stated on the trigger list and detailed in the AE policy it would be the expectation that a SAER would be required for these events.
- Moderate events listed (pg 2), based on local arrangements, require to have a service led review i.e Complex Case Review (CCR), drug and alcohol death cluster review or CPR SBAR review as stated on the trigger list. **Review type indicated in bold .**

HIS Risk Matrix definition	Extreme	Major	Moderate
Relevant categories			
Injury (physical and psychological) to patient/visitor/ staff	Incident leading to death or major permanent incapacity.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Agency reportable, e.g. Police (violent and aggressive acts, Significant injury requiring medical treatment and/or counselling.
Patient Experience	Unsatisfactory patient experience/ clinical outcome; continued ongoing long term effects	Unsatisfactory patient experience/ clinical outcome; long term effects – expect recovery >1wk.	Unsatisfactory patient experience/ clinical outcome; short term effects – expect recovery <1wk.
Local guidance	**Extreme**	**Major**	**Moderate**

General – affecting patients	Unexpected death **NEVER EVENTS** **General** - Falls from poorly restricted windows - Chest or neck entrapment in bedrails - Transfusion or transplantation of ABO-incompatible blood components or organs - Misplaced naso- or oro-gastric tubes in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration - Scalding of patient by water used for washing or bathing - Unintentional connection of a patient requiring oxygen to an air flow meter	Cardiac arrest - **CPR SBAR and dedicated review process**	Health care acquired infections. Catheter related E-coli - **CCR** SABS - **CCR**

Medication Incidents	Any medication incident resulting in death of a patient
	
	NEVER EVENTS
	Medication
	- Mis-selection of a strong potassium containing solution
	- Administration of medication by the wrong route **as follows:**
	  o intravenous chemotherapy by the intrathecal route
	  o oral/enteral medication or feed/flush by any parenteral route
	  o intravenous administration of an epidural medication that was not intended to be administered by the intravenous route*
	- Overdose of insulin due to abbreviations or incorrect device
	- Overdose of methotrexate for non-cancer treatment
	- Mis-selection of high strength midazolam during conscious sedation
		Missing stock
		- Controlled drugs
		- attractive drugs
		Missing prescription pads
			Adverse drug reactions resulting in an increase in treatment

Falls (Definitions adapted from NHS England (2024) Policy guidance on recording patient safety events and levels of harm)	Inpatient falls resulting in death	Inpatient fall resulting in significant harm **at least one** of the following apply: • permanent harm/permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment	Inpatient fall resulting with moderate harm – **CCR** **at least one** of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention

		• has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more.	• has limited or is likely to limit the patient's independence, but for less than 6 months
Tissue Viability	Unexpected death directly resulting from pressure ulcers acquired within receiving NHS Care	Grade 4 pressure ulcer acquired by a patient receiving NHS care	Grade 3 pressure ulcer **-CCR** • All ungradeable pressure ulcers will be re classified by Tissue Viability or Podiatry once a grade is established regardless of how long the wound remains upgradeable. They will be then follow the appropriate process for that grading. (Datix may require to be down/up graded to reflect actual outcome) • Multiple pressure ulcers should be graded by the ulcer of the highest severity and follow the process described.
General – affecting staff	Unexpected death, directly related to work	Any RIDDOR Reportable notifiable injury Further information available here	
Mental Health	Unexpected death of a patient detained under the Mental Health Act. Suicide of an In-patient **NEVER EVENTS** **Mental Health** - Failure to install functional collapsible shower or curtain rails - failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide	Patient suicide while patient is under the care of Fife H&SCP Mental Health **Services** **(SBAR not required, managed through Community Suicide Cluster Review process)**	Serious injury to other patients/staff caused by a patient receiving care from Mental Health and/or Learning Disability Services Unexpected death (other than suicide) of a person while patient is under the care of Fife HSCP Mental Health and Learning Disabilities' service.

Addiction services		Unexpected drug/alcohol related deaths **(SBAR not required, managed through cluster review process)**	
Maternal and Neonates	Maternal Death of a mother who has given birth within the last year Unexpected early neonatal death (>37weeks) within 7 days of birth	Neonatal hypoxic-ischaemic encephalopathy (HIE) requiring therapeutic hypothermia Unexpected stillbirth during inpatients stay	Unplanned hysterectomy -**CCR** Neonatal Death <37 weeks gestation - **CCR + PMRT** Antenatal stillbirth - **CCR + PMRT**
Surgical	**NEVER EVENTS** **Surgical** - Wrong site surgery (excludes removal of wrong teeth)		

Appendix 3

Reviewing major/extreme harm adverse events (AE)

Note: words in *italics* contains links to additional informtion/documents

Stage - Commissioning

Select appropriate review type as supported by AE policy

- **Cardiac arrest review *TOR process map***
- **Drug and Alcohol & death cluster review *TOR process map***
- **SAER**
- **SUDI *TOR process map***
- **Community suicide cluster review TOR Process map**

Scope for review set by MD/ND at SAER Panel and shared with service senior managment team (SMT process map)
SAER Sponsor (SS) allocated by Fife AE team (SS role)

Principles of review:
- **no blame**
- ***human factors*/systems approach**

Stage - Review and Analysis

Planning
-Lead reviewer (LR), Technical Lead (TL) reviews scope with SS, requests for ammendments/additions to SAER Panel
- Considers initially staff who need to be interviewed/involved
- Plan dates for follow up meetings/draft reports to adhere to target completion date

Information gathering
collate approprite documentation/information , e.g. patient records, results, rotas, guidlines

Timeline
- TL produces timeline of events.
- LR&TL agree gaps in informtion and potential key issues to be explored.
- LR, TL (SS when required) identify expert review team members required
- LR, TL confirm staff who required to be contacted/interviewed

Interviews
arrange *interviews* of staff/collect factual accounts

Analysis
Review team (including expert members) meet to carry out *analysis* to identify key issues, contributory factors and make recommendations

Stage - *Report Writing*

Draft *report*
- LR/TL produces draft report including recommendation and learn summary and agrees with review team members
- Draft report sent to SS for 1st level sign off

Final report
SS/LR submits report to Fife AE for review at SAER Panel

Approved Report
SAER Panel approves report and send back to review team and SMT

Stage - Improvement/action Planning

Improvement plan
SAER review outcome code 1,2,3
- SMT to work with clinical team to develop *effective actions*

Improvement plan submission
Completed plan to be submitted to Fife AE for adding to datix

Monitoring and closure of actions
Actions to be monitored by SMT throught local governance structures and issues escalated where appropriate

NHS Fife E-Coli CAUTI Review Process

Appendix 4

1. ECOLI CAUTI IDENTIFIED

- Record in datix **Incident category** under "Catheter related incident"
- Under **Incident sub-category** choose "Infection or CAUTI related"
- From the additional questions select "Yes" for *E.coli*

2. NOTIFICATION

- In Datix complete reviewer details most relevant for the the area that provided the clinical care these are:
- HSCP - to DN Team leader
- Acute - to Senior charge nurse (tbc)
- Care home - to care assurance hub (fife.carehomesupporthub@nhs.scot)
- Sureviellance team to attached CCR & Investigation tool for CAUTI related ECB to the Datix for reviewers to use.

3. Complex Care Review

- Reviewer with input from the clinical team completes the CCR within 30 days of the incident report . CCR sent via email attachment to technical advisors (Candice Ross & Dr Morris) for comment prior to CCR submission to HoN.
- HSCP - Reviewer submits the CCR to Head of Nursing for approval and HSCP CCGT. Method: DN Team leader uploads completed CCR and sends email from Datix to notify HoN ready for review.
- ASD - Process to be confirmed
- Care home -Reviewer submits the CCR to Head of Nursing for Care homes for approval and HSCP CCGT. Method: DN Team leader uploads completed CCR and sends email from Datix to notify HoN ready for review.

4. Approval

- HSCP - HoN approves CCR and agrees learning plan within 10 working days. After approval HoN notifies Team Lead who will upload actions & complete the Datix. Approved CCR is sent to UCIG chair for distribution to Working sub group of UCIG
- Care home - HoN for Care homes agrees learning plan within 10 working days. After approval HoN notifies Team Lead who will upload actions & complete the Datix. Approved CCR is sent to UCIG chair for distribution to Working sub group of UCIG Approved CCR is sent to UCIG chair for distribution to Working sub group of UCIG
- ASD - Process to be confirmed

Notes on who is responsible for each section in the CCR process

<u>Sections 1 and 2</u>

These sections are completed by the Infection Prevention & Control Team. Once the IPCT submit the Datix it is the responsibility of the local team to complete Section 3. (Bowel & Bladder Health) & (consultant microbiologist) should be notified of the Datix being issued

<u>Section 3</u>

Is completed by the local team leader responsible for the patient when the CAUTI related ECB occurred. Once the CCR has been undertaken it is attached to the completed Datix and sent to the HoN responsible for the clinical area where the CAUTI related ECB occurred.

<u>Section 4</u>

Is the responsibility of the HoN. HoN reviews the CCR and Datix and requests any changes. Once they are satisfied with the Datix and CCR, the CCR is sent to the chair of the UCIG.

<u>Section 5</u>

Once the Datix and CCR are approved by the HoN the Datix it is closed by Team Leader (in HSCP)

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Briefing on the NHS Dumfries and Galloway Cyber Incident**
Responsible Executive:	**Alistair Graham, Director of Digital & Information**
Report Author:	**Allan Young, Head of Digital Operations**

Executive Summary:

- This report outlines the learning and observations associated with the NHS Dumfries and Galloway Cyber Incident and seeks to provide assurance to the Committee.
- The situation and background sections outline the specifics of the incident and a general update for the cyber threat in general. This indicates the cyber-attack as human-led rather than something pre-programmed, such as WannaCry in 2017.
- A brief explanation of how the NHS D&G Cyber Attack was discovered and manifested itself, is included along with an attack timeline and high-level summary of the impact and multi-agency response.
- There is a summary of the key Cyber Threats in 2024.
- Reflecting on and exercising the elements highlighted has resulted in several technical controls and risk mitigations being identified and progressed. This includes the importance of Multi Factor Authentication, which reduces the risk of threat actors being able to use compromised credentials.
- Finally, the paper includes a general risk assurance table based on the current cyber threat level and seeks to provide a moderate level of assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

Given the rise in successful and significant targeted cyber intrusion activity within Public Sector organisations, the current threat level of a successful cyber-attack remains very high.

The Digital & Information Board consider this item at their July meeting and requested this matter be escalated to Clinical Governance Committee via the Executive Directors Group.

The paper contains high level information shared from the recent NHS Dumfries & Galloway (NHS D&G) cyber incident, which inaugurates the "human-led" cyber-attack rather than one operated by programmed code alone (Wannacry). The attack was much more sophisticated and dynamic on NHS D&G and continued to be human led even through the response phases.

The paper is provided for assurance.

2.2 Background

Cyber-attacks continue to become alarmingly sophisticated in 2024 and have caused significant immediate and medium-term impact on organisations and their ability to provide services in NHS England and patient data theft in NHS Scotland.

These attacks use email as the primary point of entry (75% in 2023). Cyber threat actors use increasingly effective methods to trick humans into downloading malicious tools designed to find and open other technical vulnerabilities deeper inside the network. This technique exposes these vulnerabilities to a human operator to continue their surveillance and is consistent with the method used against D&G (See Appendix 1). NHS Fife has elements of exposure from its use of legacy applications that operate on unsupported platforms. These systems are often considered critical to business and clinical functions but remain without funding to upgrade or replace.

NHS Dumfries & Galloway Cyber Attack High Level Summary & Timeline

In early February 2024, the UK National Crime Agency (NCA) contacted NHS Dumfries and Galloway to inform them that a Threat Actor (TA) had compromised their network. The NCA will not disclose how they had obtained this intelligence, but it triggered D&G Digital Team and NSS Cyber Incidence Response to investigate.

As part of this response Microsoft Defender for Enterprise (MDE) and Microsoft Defender for Identity (MDI) were rapidly deployed to provide a snapshot of any sinister activity. These 2 tools are a key part of the Microsoft 365 security suite allowing each device to detect and report anything out of the ordinary, building a full picture to assess.

Combined with the tools above, sophisticated 'threat hunting' and technical forensic examinations were conducted across the IT estate, along with preventative activities to protect elevated access accounts etc. Microsoft 365 & SWAN teams prepared actions to

contain NHS D&G if deemed necessary due to risks of propagation to other organisations.

After 7 days of investigation and assessment, it was discovered that the Remote Access Solution Virtual Private Network (VPN) appliance had been compromised. The VPN appliance was shut down and investigations continued to trace unauthorised activity. The shutting down of the VPN then made remote connections inoperable. One impact being no staff member connecting from home would be able to establish a remote connection from a Laptop.

Unfortunately, on day 8 it was discovered that data had been staged for exfiltration (theft), this meant that there was a significant risk that data theft had already taken place.

In early March malicious activity was detected on a second VPN appliance, but this was quickly detected by the MDE / MDI tools and shutdown (See appendix 2 for timeline picture).

On 15th March a briefing was held for Digital Leads informing of the attack, and the story broke in the media later that morning. [NHS Dumfries and Galloway fears hackers have stolen patient data - BBC News]

On 26th March the threat actor issued a ransom demand and published samples of stolen data on the dark web (See appendix 3), this was media news on 27th March. [Hackers threaten to publish huge cache of NHS Scotland data - BBC News]

On 7th May the threat actor published a large volume of patient data onto the dark web. This included BioChem Reports, Letters to patients regarding treatment, Genetics Reports, Phych Reports, Patient Names and Addresses. Children's mental health records published after cyber attack - BBC News.

2.3 Assessment

The D&I department is assessing NHS Fife's resilience level against these cyber-attacks on a continuous basis. We have accelerated the delivery of some planned improvements, found additional quick wins to improve security and conducted exercises to model the impact of the attacks witnessed.

Key Threats & Vulnerabilities in 2024

- Criminals are deliberately targeting healthcare.
- They have high capability and tools that are hard to detect.
- We have a vast and complex estate that is difficult to secure.
- We have a vast and complex supply chain.
- There are legacy systems and technologies that are most vulnerable to attack.
- NHS Scotland tolerates the adoption and use of technology that contains security weaknesses, as they are considered to provide essential functionality.
- Some NHS Scotland suppliers are heedless of the support lifecycle.
- There is limited ability for 'orchestrated' firmware level patching.
- Exposure is inevitable due to a significant digital presence and reliance.

Current Actions

- Nine recommended actions / checks provided by NSS Cyber Centre after NHS D&G incident - **Complete**
- Heightened cyber awareness at all levels - **Ongoing**
- Technical cyber-attack exercise Red vs Blue – Summer 2023 using Human Operated attack theme in real time. **Complete**
- Reviewed the learnings and created 32-point action list - **Complete**.
- Support for NISD audit action plan and cyber security roadmap – **Ongoing year on year**.
- D&I Business Continuity and Disaster Recovery (BCDR) Planning review/redesign - **Ongoing**.
- Consider further learnings and response recommendations recently published in CEO's briefing and impact of records management – **Ongoing.**
- Encourage, then Enforce Multi-Factor Authentication (MFA) on remaining logon accounts in Fife – **Complete (for M365).**
- Await formal lessons learn report from Scottish Government's Competent Authority – **Ongoing.**

The threshold for technical and security compliance has been raised for all new devices and systems that require a connection to our network. This threshold will also be used to reassess compliance for all existing devices and systems. Consideration must also be given to data sharing arrangements particularly in the area of research.

There is also work ongoing to update the Microsoft 'security baselines' (minimum levels of endpoint computer security configurations).

As mentioned in the current actions above, NHS Fife continues to deploy Multifactor Authentication (MFA) for domain / M365 access. This has been completed by NHS D&G (post attack), NHS Lothian and NHS Greater Glasgow & Clyde, to ensure all user accounts are protected by MFA. The user account initially compromised in the D&G cyber-attack was not protected, and this action was one of their first after the attack vulnerability was known. The impact of this is not considered significant because 85.5% of staff have already enrolled in MFA with it being a prerequisite to using M365 (Teams, Outlook etc.).

Much of the data extracted from D&G was archive data being held in non-secure applications such as excel and word. The information was also past its legitimate retention period or had not been properly processed following extract, processing and use without suitable deletion processes being applied.

Risk Assurance

While the approach to improvement continues in this area, the external threat remains high, and so we are only able to provide a moderate level of risk assurance in this area.

	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

Protected due to higher resilience to critical incidents. The ability to respond to an incident of this nature needs to be further tested and work is ongoing with the Resilience Planning Forum to scope a testing approach.

2.3.2 Workforce

Given the initial vulnerability continues to be generated through the actions of staff continued communication and training is a priority. The inclusion of cyber prevention training within the mandatory training scheme is a necessary consideration.

Continuous education is also a requirement for all areas of NHS Fife, where technical IT teams support their local and specialist systems.

It is critical that we understand the impact of our flexible and dynamic working practices and to continue to ensure we have a well-informed workforce that is aware of common threats and vulnerabilities.

2.3.3 Financial

Some of the next stage defences and response expertise required the removal of legacy and out of support systems. This requires resources and funding beyond the current capacity available.

2.3.4 Risk Assessment / Management

Demonstration of a mature risk management approach continues to be a requirement of the NISD Audit and is demonstrated through reporting to the Information Governance and Security Steering Group and the Digital and Information Board. The Cyber Risk associated with the corporate risk continues to be reviewed. The current risk profile and tolerance levels for Digital and Information risks are noted below. Green notes risks within the tolerance levels set.

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	15	4	10	1
Infrastructure	Moderate	14	6	7	1
Access Controls	Moderate	5	0	3	2
Information Assets	Moderate	4	0	3	1
Supplier Management	Moderate	1	0	1	0
Threats and Vulnerabilities	Low	4	1	1	2
Operational Performance	Low	6	1	4	1

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 feature of Cyber Security is a constant within the work of the Digital and Information Teams and is further supported through the Resilience Forum. Updates on progress or emerging issues are provided through the Information Governance and Security updates.

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.

- Digital and Information Board – 9 May 2024
- Executive Directors Group – 5 September 2024

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – For Members' to take a **"moderate"** level of assurance from the actions outlined in the paper.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1** - Human-Operated Cyber Attack explained
- **Appendix 2** – D&G Cyber Attack Timeline Diagram
- **Appendix 3** – D&G Cyber Attack - Ransom post

Report Contact
Alistair Graham
Director of Digital & Information
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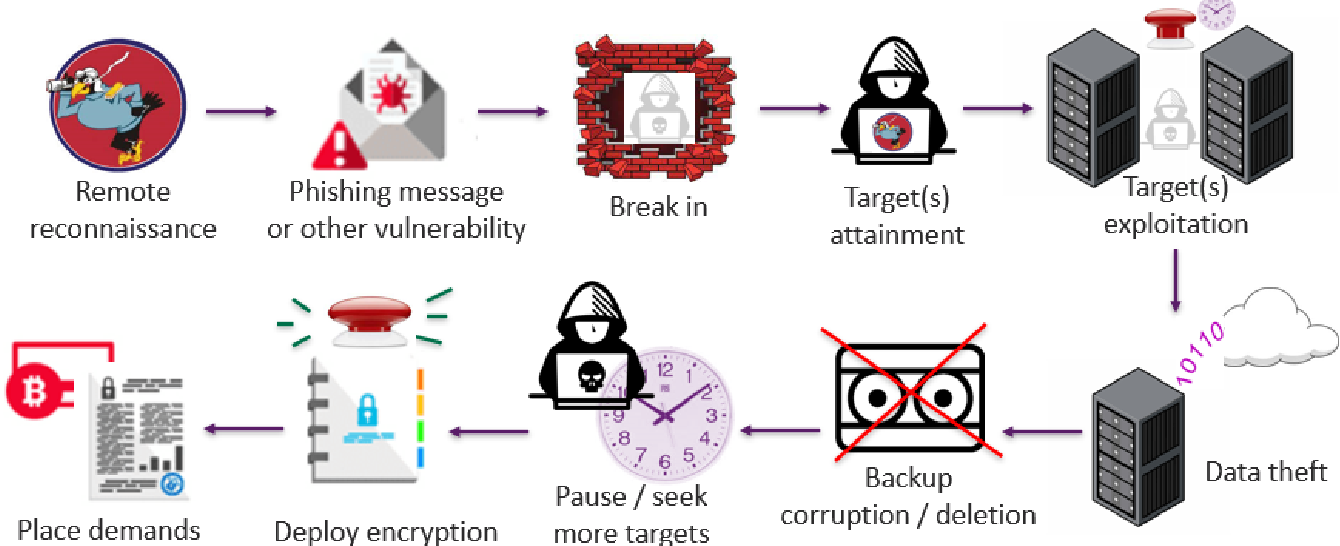
Appendix 1 - Ransomware in 2021 – Human-Operated Cyber-Attack explained



Remote reconnaissance – Potential targets will have their online presence studied to find vulnerabilities or specific targets using their own business practices. Items likely to be useful are policy & procedures, Freedom of Information, and news stories.

Phishing message – Useful information gained from remote recon will improve the chances that individuals targeted using normal business practice will be convinced by the attacker's malicious Email.

Break-in – The malicious Email convinced the targeted staff member and the attacker has a foothold. But what is different in 2021, is that the attacker is at their terminal deploying the tools required to enable the attack.

Target(s) Attainment – Once on the network, the attacker camouflages themselves in normal Network traffic and everyday commands to remain undetected. Their hunt is on for legacy systems or other targets with a low security threshold.

Target Exploitation – Once a target is found it will be exploited and used as a platform to find and attack more targets. Now the attacker will most likely to have used their toolkit to glean elevated rights on the network. They may also hedge their bets (in case of detection) by setting up a pre-configured data encryption attack on a timer button.

Data Theft – This is a 2-part attack and the exfiltration of valuable, sensitive, or personal data is one part of it. The theft will be followed later by a threat to publish the data in a public domain.

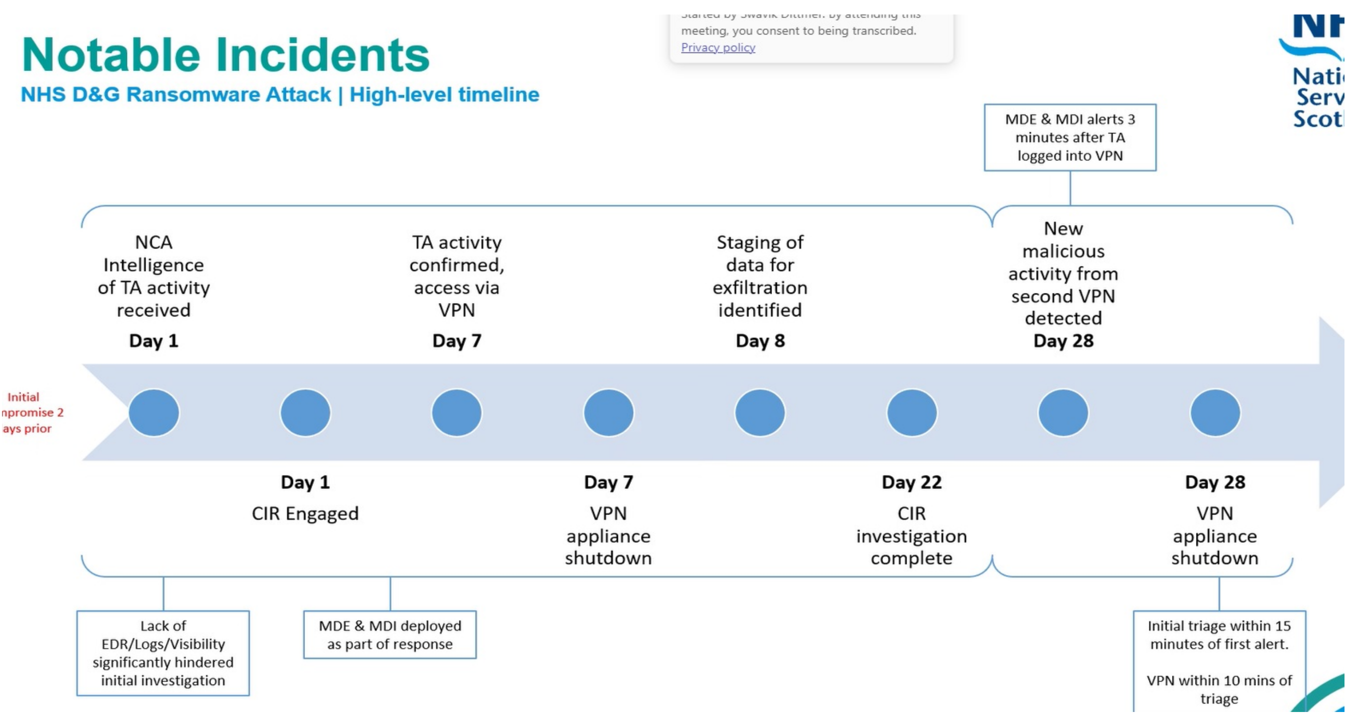
Backup Deletion – Amongst other constraints, the sheer volume of data in modern organisations prevents the use of tape backup, which once offered an obvious 'offline copy' solution. New backup solutions are fast to copy / fast to restore and replicated across multiple sites. But they need to be on the network, therefore attackers search for them with the intention to remove them as an option for restoring data that they have encrypted.

Seek more targets – At this stage the attacker has still not been detected but is poised to deliver their attack. But they may wait for their victim's worse possible moment hindering response times and maximising damage. This could be on Christmas Eve like the recent attack on SEPA, or out of hours just before month end etc.

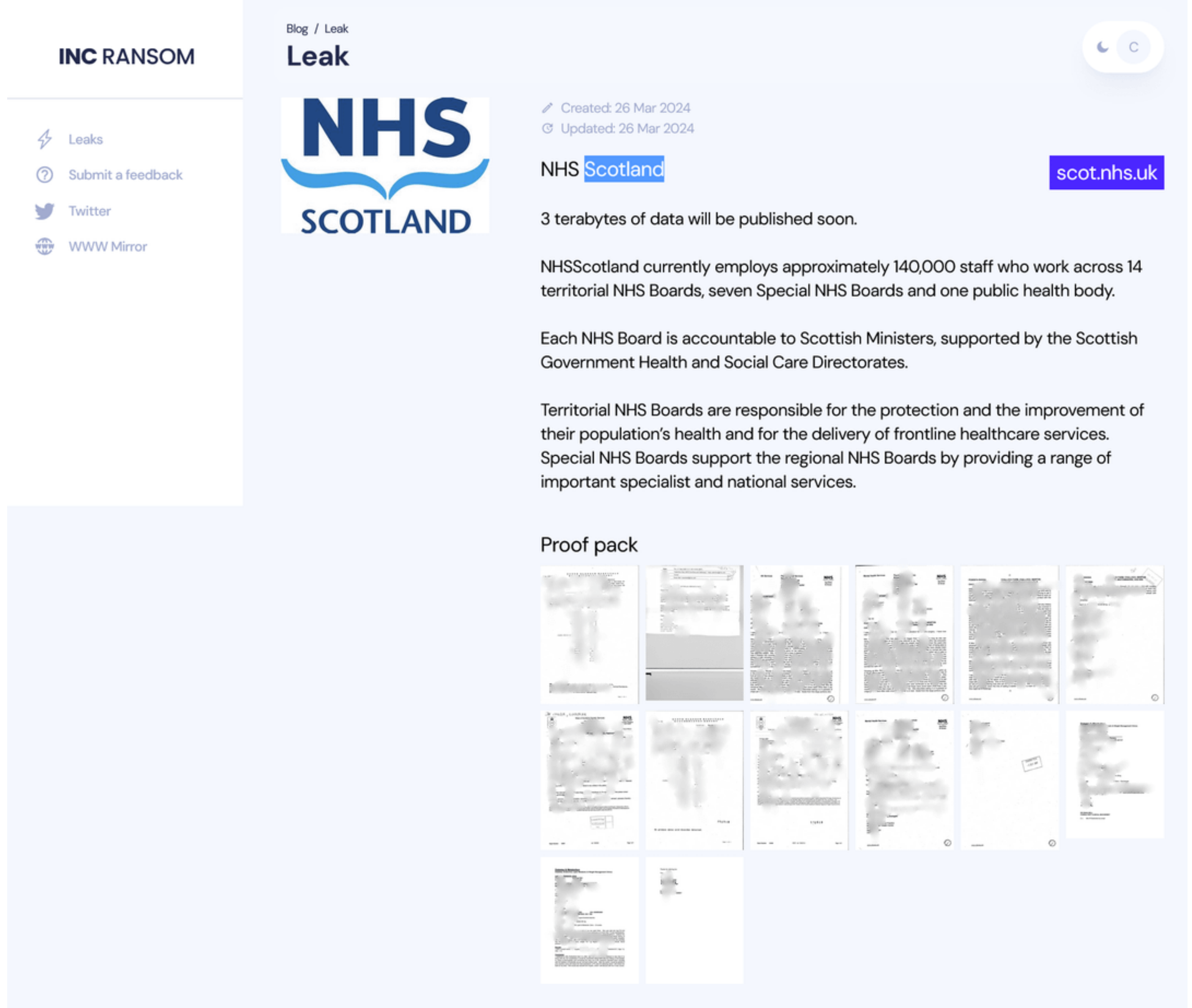
Deploy Encryption – The button is now pressed on the other part of the 2-part attack, where all data that they have gained access to is encrypted. The userbase now begins top notice as data is no longer accessible.

The Demand – Messages may pop up on all impacted computers explaining why data is not available and instructions on how to pay the ransom.

Appendix 2 – D&G Cyber Event Timeline Diagram.



Appendix 3 – NHS D&G Cyber - Ransom Post



NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Briefing Paper for Digital Strategic Framework Timeline Update**
Responsible Executive:	**Alistair Graham, Director of Digital**
Report Author:	**Marie Richmond, Head of Digital Strategic Delivery**

Executive Summary:

- This report provides the Committee with a review of the Digital and Information Strategy 2019-2024 at the end of the strategy period.
- The paper provides a reminder of the 5 key ambitions:-
  - 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.
- Of the 49 deliverables associated with the strategy, 65% have been delivered or in progress. In addition to the 49 deliverables, an additional 76 projects were identified as requirements and included National priorities as well as local requirements. Many, but not all, of these arose during the COVID pandemic response period.
- The report outlines the approach now being developed to deliver a Digital Framework, with this work expected to conclude during the remainder of the financial year.
- The report seeks to provide the Committee with a moderate level of assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- NHS Board Strategic Priorities
  - To improve Quality of Health and Care Services
  - To improve Staff Experience & Wellbeing
  - To deliver Value & Sustainability

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides an outcome report and assurance around the Digital Strategy 2019 – 2024 "Digital at the Heart of Delivery" and updates on the decision and progression to a new Digital Strategic Framework 2025-2028.

The report is provided to the Committee for Assurance.

2.2 Background

NHS Fife's Digital and Information Strategy "Digital at the Heart of Delivery" was endorsed by the NHS Fife Board in September 2020. 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 and noted, at that time, the disruptive drivers.

The Digital strategy 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.

Associated with these ambitions the strategy identified a total of 49 associated delivery items, aligned as follows: -

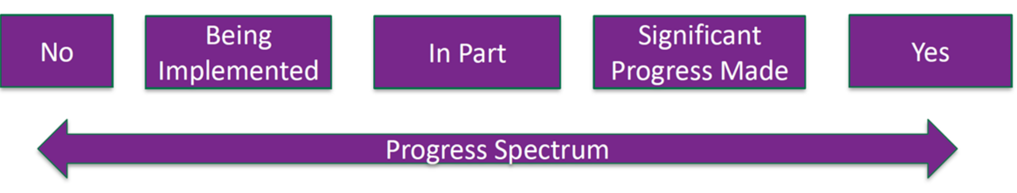
Strategic Ambition	Total Number of Deliverables
Modernising Patient Delivery	11
Joined Up Care	13
Information and Informatics	7
Technical Infrastructure	11
Workforce and Business Systems	7
Total	**49**

In addition to the stated deliverables included at the time of publication of the strategy, it was recognised a substantial level of "new" deliverables would be identified and required during the strategy period, these were requested either from National or from local requirements and a fuller analysis of these are detailed within the assessment.

A review was undertaken in 2023 which formed themes and re-aligned deliverables to the new Population Health and Wellbeing Strategy and associated programmes. It also considered alignment to other strategic drivers contained within the Strategic Plan for Fife (and associated Digital Strategy for Fife HSCP), Scottish Government's Digital Health and Care Strategy, Data Strategy and Artificial Intelligence Strategy. Other items of influence include the principles of Values Based Healthcare, NHS Scotland's Climate Emergency and Sustainability strategy and the Innovation considerations associated with our role in Health Innovation Southeast Scotland (HISES) and the Accelerated National Innovation Adoption Pathway (ANIA).

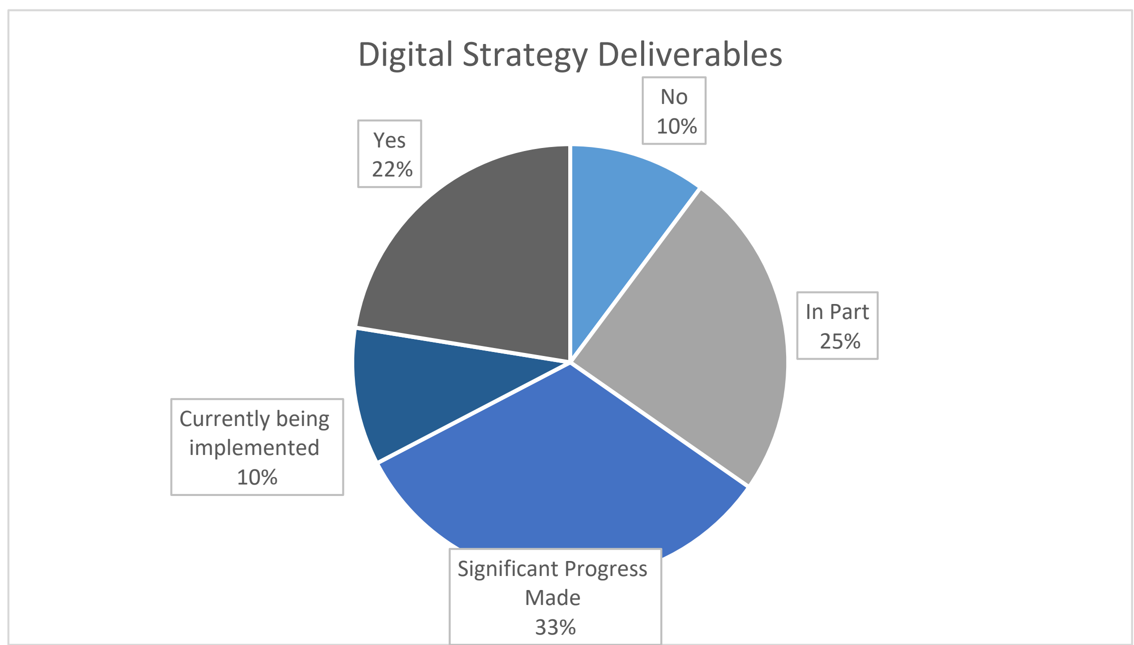
The progress spectrum used within the last update, outlined in Figure 1 below, was used to assess the level of implementation achieved for each deliverable at the strategy conclusion. The question posed is "has the deliverable been achieved?".

Figure 1 - Deliverable Assessment



2.3 Assessment

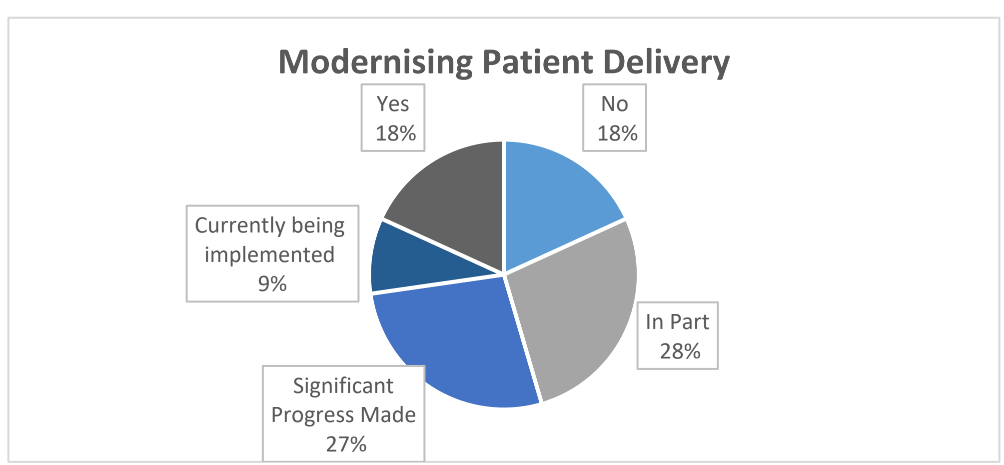
An assessment of the deliverables outlined in the strategy (as detailed in Appendix 1) was undertaken and is shown below: -



Overall delivery of the strategy has made significant progress with 65% of deliverables having been delivered or being currently implemented with significant progress made. Some deliverables have experienced delays, during the strategy period due to the impact of Covid 19 requirements, the additional deliveries that emerged and National delivery delays.

A breakdown of the individual areas is shown on the following pages.

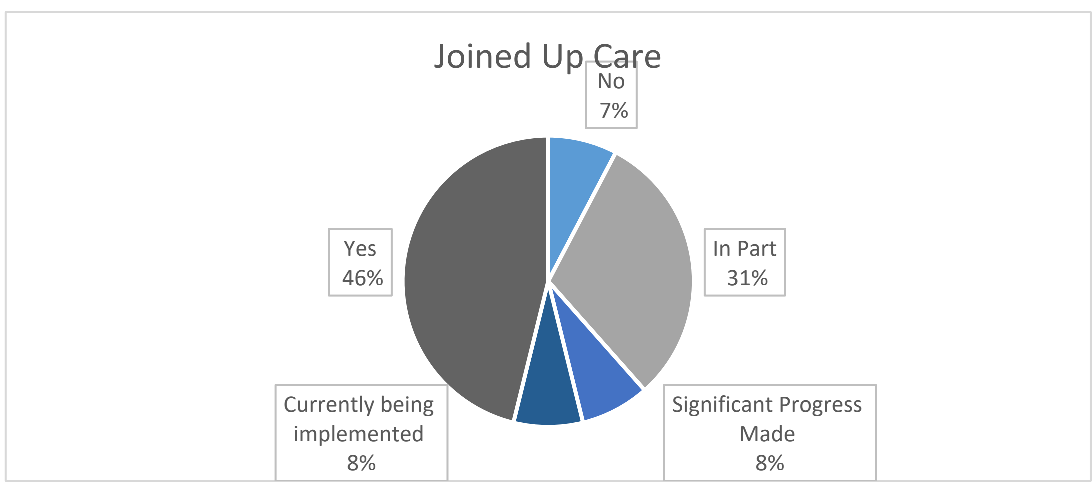
Modernising Patient Delivery



Just over half of the projects which were outlined within the plan, have either been delivered or are in the process of being delivered. The projects which have not been delivered were nationally directed and non-delivery was out with our control. The greatest progress has been in the optimisation of outpatient appointments and LIMS. We have also implemented

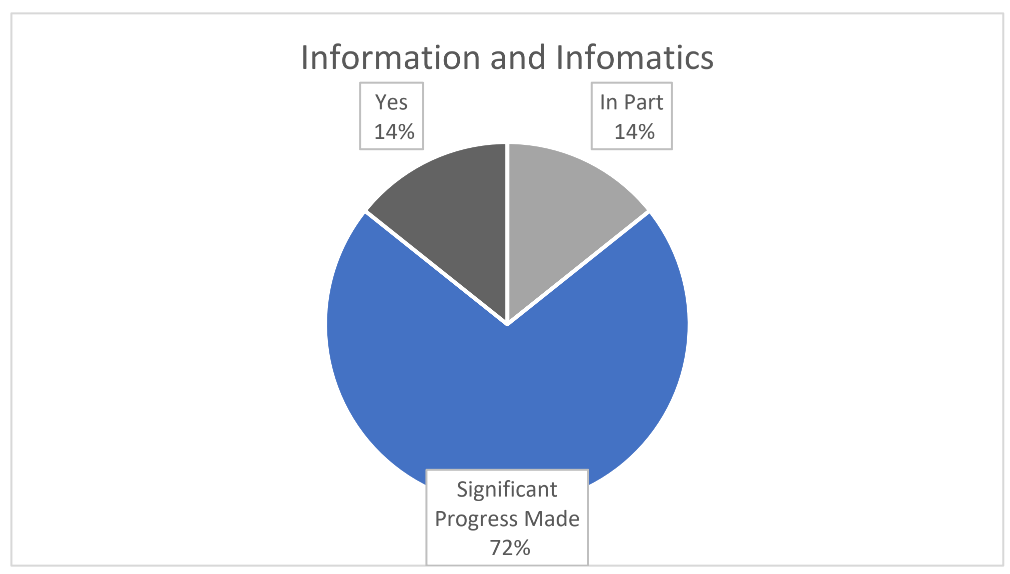
key functionality withing Patient Hub, including waiting list validation to support improved communications with patients. The areas which are in delivery will be key to our framework moving forward as we focus on the benefits that digital can bring both to the patient and those providing their clinical care.

Joined Up Care



46% of Joined Up Care projects have been delivered, 47% are in varying stages of delivery, with impact to timelines being largely down to either national or contractual delays. The 1 project which makes up the 7% not delivered was neurology which did not proceed at a national level. All the projects which are in delivery will be candidates for the new framework as we continue our journey towards the Once for Scotland agenda and integrated care objectives, with a maturing in data availability, to support clinical decisions at the point of care and patients investing in their health and wellbeing.

Information and Informatics

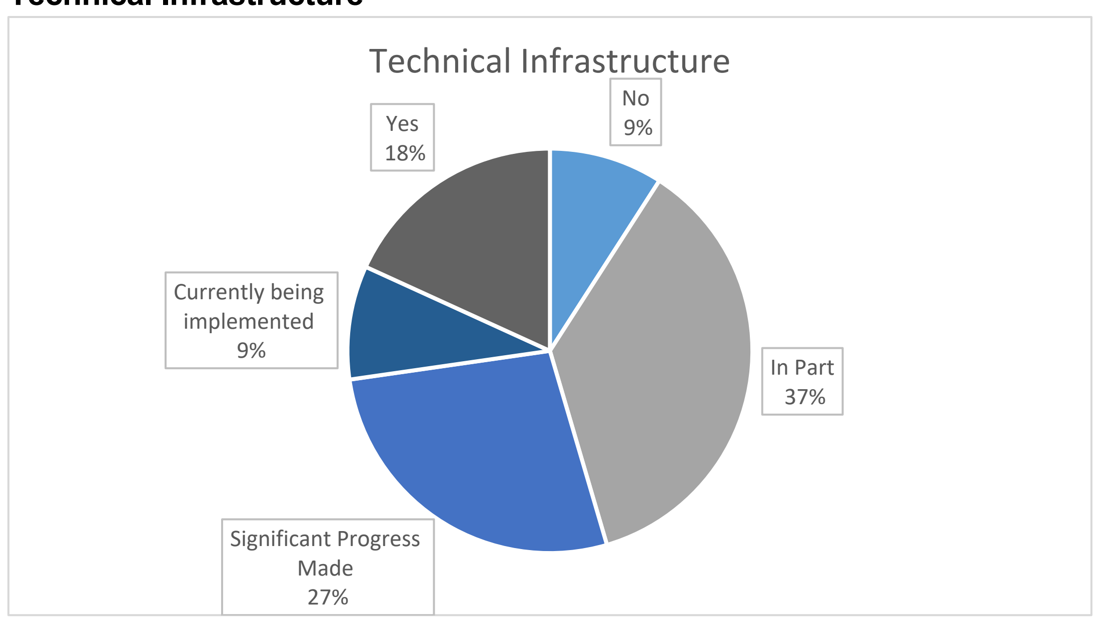


14% of projects within this area were completed. However, this area by its very nature has several projects which will remain ongoing as part of lifecycle delivery and therefore they have been assessed as either delivered in part or significant progress made. These projects

will carry forward in some form into the new strategic framework, where there will be a recognition of the importance of data to support clinical service delivery and effective patient care. Data insight, for planning, operational decision making, performance and outcome monitoring, research and innovation remain key as we develop new models of care. This insight will be particularly clear as we develop our approach to risk stratification for our patients.

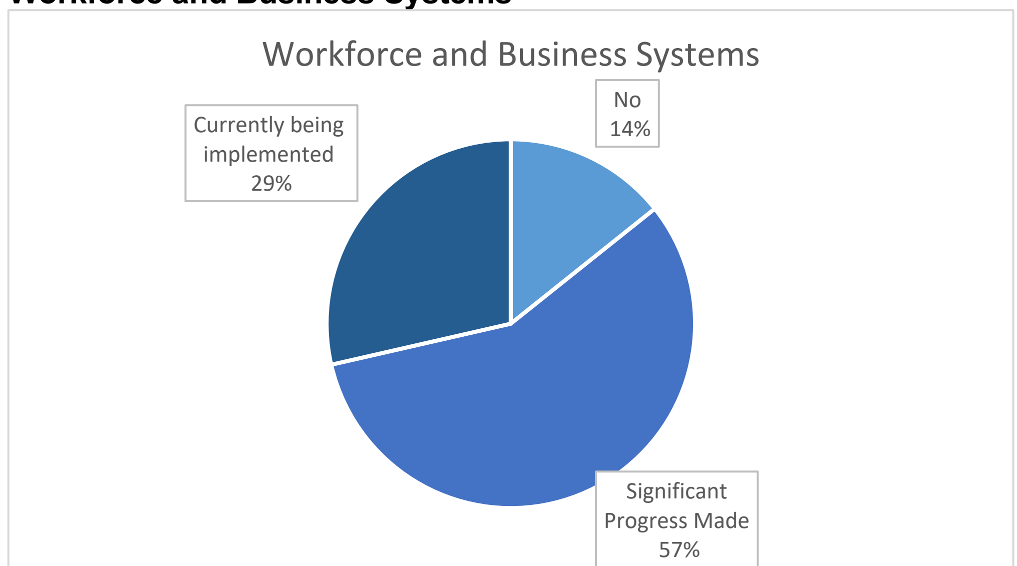
The continued development of our privacy and security programmes ensures the safe and appropriate handling of data will remain a key component of our future framework.

Technical Infrastructure



The challenges which have been experienced within this area mainly relate to the financial ability to support a sustained move from capital expenditure to one of revenue that is being driven by suppliers. This was recognised as a disruptive factor and key concern when the strategy was completed and has been identified within previous updates. While investment during the COVID period was available, the lack of recurring support puts at threat some of the improvement made. There has also been delays in the introduction of the National Digital Platform which has resulted in the 9% area of non-delivery. There has however, been significant progress in several key areas including the Cyber Essentials/NIS requirements and our alignment to the Information Commissioners Office (ICO) Accountability Framework, with a vastly improved score for 2024/25. In a similar manner to Information and Informatics the deliverables within this area will carry forward into the next framework as they are recognised as key operational activities which support the effective running of our technical infrastructure.

Workforce and Business Systems



All but one of the projects are in progress with over 57% showing significant progress, there were some delays due to National and in some cases limited resources to move areas forward at the appropriate pace. The only objective which has not moved forward in this area has been the implementation of a more virtual workforce with modernisation of ways of working, whilst this has not been achieved within the current strategy, this will be key to delivery within the next framework with a focus on how digital can support the more repetitive tasks within the NHS environment. Our workforce remains one of the largest assets within NHS Fife and this will be recognised within our next framework.

Additional Requested Deliverables

In addition to the projects which were originally outlined within the digital strategy, through the 5 years of the strategy a further 76 projects have been delivered over the 5 years since the strategy was agreed. 20 requests were additional strategic deliverables from National with the remaining 56 requested to meet the needs of NHS Fife's local priorities, strategies, or programmes. 79% of the projects have been completed fully with the remaining 21% in progress and scheduled for completion. A significant number of these were a direct result of the NHS Fife response to the pandemic and the learning during this period continues to be considered in our approach to technology adoption.

Digital receive multiple requests for support through the digital health and care requests process and this demand exceeds capacity. Improvements continue with alignment to emerging organisational or National priorities to ensure the pathway for digital delivery is clear to support the objectives and strategies within the organisation.

Strategic Framework 2025-2028

As the development of a revised strategy began, several factors were identified and changed, 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 arrangement, yet to be fully implemented, for Digital and Data within Scottish Government.
- Review of existing delivery models for digital capability at a national and regional level.
- 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 care record.
- The scale of the current financial challenge.
- The development of the Re-Form, Transform and Perform Framework (RTP).

Following updates in relation to delivery and recognising the challenges which are facing NHS Fife in July through corporate objective setting and the Digital and Information Board supported the move to a digital strategic framework, given the degree of change which is forthcoming within the national arena for Digital and Data and the need to support the requirements of NHS Fife's RTP Framework.

The framework would have a more direct alignment to the schemes within the RTP, take less time to produce and provide time for the factors outlined above to be resolved or progressed.

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 has been established, with a focus on 3 Key Objectives: - Digital transformation of the paper record, which is currently held for the patient, Prevention of any new paper being added to this record and supporting our service users through implementation and improvements to Our Digital Front Door. Successful delivery of EHR will further reduce our reliance on paper and maximise our clinical capacity.
- To develop our 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, improve the systems they do use, 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.

Work is ongoing to deliver this framework and meetings will be held with key stakeholders over the next 4-6 weeks with the intention that the strategic framework will be presented to the Digital and Information Board in January 2025, with progression and consultation concluding by March 2025.

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.	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 refresh of the digital strategy allows for appropriate realignment to our revised strategies and the ambitions contained within them.

The work associated with the digital front door will provide the ability for patients, their families, and carers to contribute to their health record is a fundamental requirement to support the necessary conversations at the heart of Value-Base Health Care.

Each of the deliverables have been subject to both lessons learned, and review of benefits achieved, this has supported effective delivery moving forward with the proposed introduction of an updated framework for project delivery.

Engagement will be key to successful delivery of a revised framework, as delivery must be service rather than digitally led to ensure critical success factors are met. There will be increased focus on Clinical safety of design, operational capability, and ongoing review of digital systems.

The 3 elements above will be critical to development of the digital strategic framework 2025/28.

2.3.2 Workforce

Many of the deliverables which are in progress or have been achieved have impacted the workforce within NHS Fife. These deliverables can be challenging for teams to absorb alongside their current operational duties and therefore a key focus of the next strategic framework will be the importance of digital enablement within our workforce, and a recognition of the need to phase delivery to prevent digital fatigue. We will work closely with colleagues in Partnership and Workforce to ensure this support is well designed and considered.

The key fundamental of successful delivery is the digital workforce being capable of delivering of the innovations and ambitions set out within the new framework and this has been recognised by Digital and Information SLT and will be directly considered as part of the digital strategy refresh and outlined in the mitigating actions.

2.3.3 Financial

The scale of the ambition in the strategy and the financial impact associated continues to be a risk that is managed. 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. This has proven challenging over the last year with new initiatives being agreed with no funding to support local implementation and some programmes which are in progress taking substantially longer to deliver than expected. This leads to a challenge in meeting delivery needs.

Additional risk is also associated with the medium-term cost to digital capability that was introduced as a direct response to the COVID-19 pandemic. Digital have been working to reduce this spend, and as part of the Reform, Transform, Perform (RTP) ambition within Fife have substantially contributed to savings through the dissolution of systems and improved contract and supplier management practices.

The refreshed strategic approach will be accompanied by a financial framework and note the requirement for continued support of the RTP ambition.

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 Information Governance and Security Steering Group and Digital and Information Board.

A formal risk appetite and tolerance statement was agreed by the Steering Group and Board in 2023 which has allowed a refreshed reporting of Risk controls and mitigations.

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

Each relevant programme of work is subject to an EQIA. As part of the revised framework a refreshed Equality Impact Assessment will be conducted which will cover the overall delivery of digital solutions.

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

- The Digital and Information strategy was discussed at all relevant Groups and Committees prior to sign off by the NHS Fife Board.
- The challenges outlined have been presented to the Digital & Information Board and form a consistent part of that group's workplan with regular reporting on the challenges.
- The engagement model will continue to be further developed with the Head of Digital Strategic Delivery focussing on the business relationship and engagement models.

2.3.8 Route to the Meeting

The topics have been considered by the following groups as part of its development.

- Digital and Information SLT
- Digital and Information Board

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a **"Moderate" Level of Assurance** over the delivery of the Digital Strategy 2019-2024 and provides an outline and timeline associated with the development of the Digital Strategic Framework 2025-2028.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, 2019 – 2024 – Strategic Deliverables

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Appendix 1 - 2019 – 2024 – Strategic Deliverables

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for Strategic Framework?
1	**Modernising Patient Delivery** Ensuring we provide our patients/service users with a modern fit for purpose health care service. This incorporates ambitions which were laid out by the Scottish Government in "The Modern Outpatient: A Collaborative Approach 2017-2020", which aimed to provide service users with timely access to advice, treatment and support with minimum disruption when clinically appropriate.	1.1	Clinical Decision/Advice Improve through joining up and improving existing systems.	Yes	In Part	Yes
		1.2	Consultant to Consultant Send and receive information electronically from other Health Boards.	Partially	Significant Progress Made	Yes
		1.3	Digital Maturity Assess the digital maturity of our IT, in order to identify the priority areas for improvement.	National	Significant Progress Made	Yes
		1.4	Digital Hub Changing the way we communicate with our patients and citizens.	Yes	In Part	Yes
		1.5	GPIT Replacement Modernisation as part of a wider National programme.	Partially	In Part	Yes
		1.6	LIMS replacement Laboratory Information management system (LIMS), support implementation of replacement hardware whilst a new regional system is procured and implemented.	Partially	Currently being implemented	Yes
		1.7	Near Me Video conferencing for our service users to engage with clinicians with minimal disruption.	Yes	Significant Progress Made	No
		1.8	Optimisation of Outpatients Appointments Patient focussed/ self booking, patient initiated follow up appointments and review of clinical letters.	Partially	Currently being implemented	Yes
		1.9	Paperlight Reduce the reliance of paper with the ambition of 85% paperlight by 2022.	Yes	In Part	Yes
		1.10	Technology Enabled Care Support projects which provide care to the patient within their home environment.	National	In Part	Yes
		1.11	Theatres system replacement The system currently in use within Theatres requires replacement.	National	No	Yes
2	**Joined Up Care** NHS Fife continues to work on utilising digital to provide joined up services across primary, community, acute and social care to ensure all relevant information is available to those working with our service users. The new GP Framework Contract (2018) recognised one of the most challenging aspects of being a GP was workload. The contract committed to implement the recommendations of the Improving General Practice Sustainability Advisory Group report (2016), which identified a number of broad themes including effective primary and secondary care interface working. In addition, the contract committed to Health and Social Care Partnerships and NHS Boards placing additional primary care staff in GP practices and the community to work alongside GPs and practice staff to reduce GP practice workload. Implementation of digital changes and improvements to systems supports this delivery. The areas identified within this category all support the need for a more integrated care environment.	2.1	Bedside Risk Assessment Ensuring assessment of clinical risk is conducted at bedside.	Yes	Yes	No
		2.2	CHI Replacement Modernisation of Community Health Index as part of a National programme	National	Significant Progress Made	Yes
		2.3	Child Health Replacement Modernisation of the current Scottish Child Public Health and Wellbeing solution as part of a National programme	National	In Part	Yes
		2.4	Community System Replacing an end of life system (MiDIS) with a more integrated solution.	Yes	Yes	No
		2.5	Community Pharmacy Access Connecting Community Pharmacy to other NHS Fife services	Yes	Yes	No
		2.6	Health and Social Care Portal Extending use to include more services and social care services	No	In Part	Yes
		2.7	HEPMA Hospital Electronic Prescribing and Medicines Administration	Partially	No	Yes
		2.8	Mental Health Pathways Ensuring pathways are implemented within our digital environment.	Yes	In Part	Consideration
		2.9	Neurology Electronic Referral implementation of an e-Referral system for Neurology.	No	No	No
		2.10	Palliative Care Plan Improve palliative care provision through digital.	Yes	In Part	Yes
		2.11	Pharmacy Redesign Redesign pharmacy, introduction of robotics and falsified medicines within NHS Fife	Yes	In Part	Yes
		2.12	Trakcare Maximum Utilisation Achieve maximum benefit by implementing changes requested by practitioners.	Yes	In Part	Yes
		2.13	Women and Children's Redesign Site optimisation exercise to which digital delivery of service will be fundamental.	Yes	In Part	Yes

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for Strategic Framework?
3	**Information and Infomatics** Effective use of information is a key component of the Digital and Information Strategy. High quality information enables NHS Fife to plan, manage and monitor effectiveness. This ensures services are best-equipped to cater for users within Fife whilst also ensuring maximum benefit in terms of health outcomes, level of care and cost. Management Information must be readily accessible to all those who require information at the point that they need it. We need to provide our staff with reporting tools and reporting solutions that are accessible and intelligible. We are committed to ensuring that our digital ambitions are robustly supported by information at the centre of delivery and ensure that these deliveries are well-planned and appropriately resourced. NHS Fife recently delivered an extremely successful informatics project - Fife Early Warning Score (FEWS) was the culmination of IT, reporting, and clinical rules-based expertise. This was a very successful collaborative approach and points a way forward for NHS Fife, combining clinical rules-based knowledge with information and technology to move services forward. Increased use of dashboard visualisations, a focus on trigger reports, and alerts generated by our Patient Administration Systems will ensure that our collective data assets are more proactive and productive.	3.1	Business and Health Intelligence This is central to business as usual processes across NHS Fife.	Yes	Significant Progress Made	Yes
		3.2	Convergence of Obsolete Systems and Methods of Holding Data convergence of data from applications which are no longer supported or are classed as at risk from cyber security	Partially	In Part	Yes
		3.3	Fife Safe Haven An invaluable resource for researchers to tackle future healthcare provision and disease management.	Yes	Yes	Yes
		3.4	GDPR / Data Protection Act 2018 Ensuring NHS Fife remains compliant will GDPR, information security and any relevant governance.	Yes	Significant Progress Made	Yes
		3.5	Improving Data Quality Influence data collection standards and champion data quality as a key organisational asset	Yes	In Part	Yes
		3.6	Management Information Hub Central, accessible and intelligible resource for the organisations decision makers.	Yes	Significant Progress Made	Yes
		3.7	NIS and Cyber Essentials Ensuring NHS Fife complies with IS Legislation	Yes	Significant Progress Made	Yes
4	**Technical Infrastructure** A fuller picture of the technical work that is carried out is detailed within the 'Keeping Us Safe and Secure' section which outlines the Business As Usual (BAU) work that is undertaken. Alongside the transformational change which is outlined within this strategy there is a need to also improve the technical Infrastructure. The infrastructure ensures the changes are sustainable for NHS Fife. Management of systems and ensuring best value for NHS Fife is critically important. Best value allows NHS Fife to maximise return on investment and generate savings which can be reallocated to delivery of patient care	4.1	Adaptation of Revenue Based Business Model Suppliers are offering the best solutions and services using a revenue/ subscription based business model and we need to embrace this change.	Partially	No	Yes
		4.2	Always within Support Lifecycle Maintain all systems and solutions (hardware & software) within a current support lifecycle and manage suppliers / contracts accordingly	Partially	In Part	Yes
		4.3	Balanced use of public, private cloud and on premise solutions and resilience Adopt a balanced and risk and merit based approach to choosing public cloud, private cloud or on premise solutions	Yes	In Part	Yes
		4.4	Cyber Essentials/NIS/GDPR and Information Security Protect against cyber attacks and comply with NIS regulations, ensure network is secure, risks are understood, impact of incidents are minimised and governance is followed	Yes	Significant Progress Made	Yes
		4.5	Exit Plans for Poor Suppliers Maintain a flexible and versatile approach to supplier contracts. Maintain a product lifecycle which is secure and fit for purpose	Yes	In Part	Yes
		4.6	National Digital Platform Relevant real time data and information from health and care records and services is available nationally	No	No	Yes
		4.7	PACS Upgrade Upgrade to Picture Archiving Communications System (PACS).	National	No	Yes
		4.8	Resilient and Secure by Design Adopt best practice systems and application architectural design principles and ensure resilience, Implement solutions which have been designed with cyber security threats and vulnerabilities in mind	Partially	Significant Progress Made	Yes
		4.9	Regional IT Service Management Rollout of system within the Region and ongoing sharing of best practice	Partially	In Part	Yes
		4.10	Security Upgrades Undertake all security upgrades	Yes	In Part	Yes
		4.11	Windows 10 Ensure most up to date operating system	Yes	Yes	Yes

Objective	Key Ambition for 2019-24	Ref	D&I Work in support of Objective	Has this objective been within our control?	Has this objective been achieved?	Candidate for Strategic Framework?
5	**Workforce and Business Systems** We need to ensure that alongside delivery of this strategy we undertake true engagement with our workforce, they are central to all we do. We will balance how we deliver our ambitions with delivery of traditional medical roles. We can support our workforce by providing them with digital systems. This will ensure they receive maximum benefit with minimum systems.	5.1	Consolidating GP Business Systems Provide the most appropriate delivery of service to primary care colleagues.	Yes	In Part	Yes
		5.2	e-Rostering Regional / National e-Rostering solution to assist with staff management.	National	Currently being implemented	Yes
		5.3	Framework for Attracting Youth in NHS Digital Invest in more apprenticeships to help address the ageing workforce problems facing the NHS in Scotland	Partially	In Part	Yes
		5.4	Maximising Return On Investment Achieve maximum benefit from the systems which are in use	Partially	Currently being implemented	Yes
		5.5	Office 365 National deployment of office 365, all NHS employees in Scotland to communicate and share information from a single platform	National	In Part	Yes
		5.6	Printing Capability Review Centralising printing, to minimise costs per specialty.	Yes	Currently being implemented	Yes
		5.7	Virtual Workforce Consider modernising ways of working e.g. the use of robotics for on boarding and off-boarding of staff	Yes	No	Yes

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Medical and Dental Professional Standards Oversight Group**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards**

Executive Summary

This paper provides information on the Medical and Dental Professional Standards Oversight Group. The committee are asked to note:

- the establishment of the Group.
- that the group will report via minutes to this committee and to the Staff Governance Committee and will escalate identified risks or issues of importance.
- that an annual assurance statement for consideration by this committee and the Staff Governance Committee.
- the Terms of Reference at Appendix 1.

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 Quality of Health & Care Services
    - To Improve Staff Experience and Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides information to the committee on the Medical and Dental Professional Standards Oversight Group.

2.2 Background

The Medical and Dental Professional Standards Oversight Group was established in April 2024 with the purpose of taking the overview of the following areas within NHS Fife: -

- Medical Appraisal and Revalidation.
- Consultant and SAS doctor Job Planning.
- Oversight of all aspects of undergraduate medical education.
- Oversight of all aspects of postgraduate medical education including rota compliance, deanery visits and survey feedback.
- Oversight of all aspects of undergraduate and post graduate dental education.
- Medical Workforce strategic planning

2.3 Assessment

The Group is chaired by the Medical Director and has representation across both Acute and H&SCP (See Appendix 1)

The role and remit of the Medical and Dental Professional Standards Oversight Group is as follows:

- Monitor the delivery of the Medical Appraisal and Revalidation Framework
- To provide NHS Fife's Clinical and Staff Governance Committees with the assurance that all doctors with a prescribed connection to NHS Fife have undertaken annual appraisal and have obtained feedback from colleagues and patients, where appropriate, once in a five-year cycle thus enabling NHS Fife's Responsible Officer to make revalidation recommendations to the General Medical Council.
- To ensure all NHS Fife trained medical staff have a job plan, in line with Consultant Grade terms and conditions of service, 1 April 2007 and the New Contract for Specialty Doctors and Associate Specialists – CEL 27 (2008), and which is subject to review at least annually or more often, if changes to staffing resources, or working practices, or the consultant's circumstances require it.
- Monitor the delivery of the Medical Education Framework.
- Provide objective oversight the training of undergraduate and post graduate medical and dental staff.
- Take assurance in regard to all action plans that relate to Deanery visits.
- Take assurance in relation to all trainee survey feedback.
- Receive assurance and reports from the Medical Workforce Strategic Groups in Acute and H&SCP- specifically in relation to the use of agency medical workforce and hard to recruit to specialties.
- Take assurance in regard to action plans for non-complaint trainee rotas.

The group will:

- agree an annual workplan to ensure all relevant business is delivered.

- complete an annual assurance statement for consideration by this committee and the Staff Governance Committee.
- escalate identified risks or issues of importance to this committee and the Staff Governance 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

High quality training is fundamental to ensure sufficient numbers of doctors and dentist are trained in Scotland.

2.3.2 Workforce

Medical appraisal ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

The group will escalate identified risks or issues of importance to the NHS Fife Clinical Governance and Staff Governance Committees.

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Dr Christopher McKenna, Medical Director

2.3.8 Route to the Meeting

Dr Christopher McKenna, Medical Director, on 21 October 2024

2.4 Recommendation

The committee are asked to note the information on the Medical and Dental Professional Standards Oversight Group.

- **Assurance** - Members are asked to take a **“moderate”** level of assurance.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Medical and Dental Professional Standards Oversight Group Terms of Reference

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

MEDICAL AND DENTAL PROFESSIONAL STANDARDS OVERSIGHT GROUP

TERMS OF REFERENCE 2024-2025

1. PURPOSE

1.1 The purpose of the Medical and Dental Professional Standards Oversight Group is to take overview of the following areas within NHS Fife: -

- Medical Appraisal and Revalidation
- Consultant and SAS doctor Job Planning
- Oversight of all aspects of undergraduate medical education
- Oversight of all aspects of postgraduate medical education including rota compliance, deanery visits and survey feedback
- Oversight of all aspects of undergraduate and post graduate dental education.
- Medical Workforce strategic planning

2. COMPOSITION

2.1 The membership of the Group will include: -

Medical Director/Responsible Officer – NHS Fife (Chair)
Deputy Medical Director – Acute Services Division/Deputy Responsible Officer – NHS Fife
Deputy Medical Director – Fife Health & Social Care Partnership
Director of Medical Education
Associate Directors of Medical Education
Medical Education Service Manager
Director of Public Health
Director of Dentistry
Associate Director for Risk and Professional Standards
Associate Director of Quality and Clinical Governance
Head of Human Resources
GP Lead for Appraisal
Secondary Care lead for Appraisal
AMD rep– Fife Health & Social Care Partnership
AMD rep– Acute Services Division
Rep from General Managers – Acute Services Division
Rep from Head of Service - HSCP
LNC Representation
Medical Appraisal & Revalidation Coordinator – NHS Fife.

3. ROLE AND REMIT

3.1 The role and remit of the Medical and Dental Professional Standards Oversight Group is as follows:

- Monitor the delivery of the Medical Appraisal and Revalidation Framework
- To provide NHS Fife’s Clinical and Staff Governance Committees with the assurance that all doctors with a prescribed connection to NHS Fife have undertaken annual appraisal and have

obtained feedback from colleagues and patients, where appropriate, once in a five-year cycle thus enabling NHS Fife's Responsible Officer to make revalidation recommendations to the General Medical Council.

- To ensure all NHS Fife trained medical staff have a job plan, in line with Consultant Grade terms and conditions of service, 1 April 2007 and the New Contract for Specialty Doctors and Associate Specialists – CEL 27 (2008), and which is subject to review at least annually or more often, if changes to staffing resources, or working practices, or the consultant's circumstances require it.
- Monitor the delivery of the Medical Education Framework.
- Provide objective oversight the training of undergraduate and post graduate medical and dental staff.
- Take assurance in regard to all action plans that relate to Deanery visits.
- Take assurance in relation to all trainee survey feedback.
- Receive assurance and reports from the Medical Workforce Strategic Groups in Acute and H&SCP- specifically in relation to the use of agency medical workforce and hard to recruit to specialties.
- Take assurance in regard to action plans for non-complaint trainee rotas.

4. MEETINGS AND REPORTING ARRANGEMENTS

4.1 Meeting will be held on a quarterly basis and will be serviced by the Medical Appraisal & Revalidation Coordinator.

4.2 The Medical and Dental Professional Standards Oversight Group reports to NHS Fife's Clinical and Staff Governance Committees.

4.3 The group will agree an annual workplan to ensure all relevant business is delivered.

4.4 The group will complete an annual assurance statement for consideration by the Clinical Governance and Staff Governance Committees in advance of the group approving.

4.5 In order to fulfil its remit, the group will escalate identified risks or issues of importance to the NHS Fife Clinical Governance and Staff Governance Committees.

4.6 Local working groups will report via minutes into the group to ensure oversight and to provide assurance to this group. These groups include:

- Medical Workforce Strategic Group – Acute
- Medical Workforce Strategic Group – H&SCP
- Area Medical Committee
- Responsible Officer Advisory Group
- Medical Education Senior Leadership Team (SLT)

4.7 The following reports will be submitted to NHS Fife's Clinical and Staff Governance Committees on an annual basis.

- Medical Appraisal and Revalidation Annual Report (including a Healthcare Improvement Scotland Self-Assessment for Medical Appraisal and Revalidation)
- Job Planning Report
- Medical Education Annual Report
- Dental Education Annual Report

4.8 The group will conduct business in accordance with NHS Fife's organisational values.

NHS Fife

Meeting: **Clinical Governance Committee**

Meeting date: **1 November 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:

- **New Single Point of Contact (SPOC)**: Streamlines complaint handling process across Directorates.
- **Local Resolution Emphasis**: Encourages resolving complaints directly to enhance patient satisfaction and reduce workload.
- **Improvement**: Significant reduction in open Stage 1complaints from Q2 to Q3, showcasing improved efficiency.
- **Quality Assurance**: New factual account template improves response quality and reduces redundancy.
- **Performance:** September 2024 saw 37 Stage 1 complaints received, with 39 closed.
- **Performance:** Compliance within timescales for Stage 1 complaints was at 48.7%; overall compliance was 51.5%.
- **Performance:** 67 S2 complaints with various delays in processing.
- **Performance:** September 2024 saw 33 Stage 2 complaints received, with a 25.7% compliance rate for timely closures.
- **Performance:** This is a 53% improvement on the average days to close a Stage 2 complaint which is 44 days compared to September 2023/24 which was 94 days.
- **Performance:** 18 open SPSO cases with 6 Support Intervention Policies
- **Dashboard Utilisation**: Provides clarity on complaint status with further work required.
- **Challenges**: Not meeting the 60% target for S2 complaints closed within 20 days, although showing improvement trends.
- **Promotion and Training**: Regular support visits to clinical areas to encourage staff engagement with Care Opinion.
- **Volunteer Recruitment**: Aiming to gather diverse Care Opinion patient stories, particularly from underrepresented groups.
- **Positive Outcomes**: Notable increase in Care Opinion patient stories collected during Q2.

Focused actions are needed to enhance compliance and effectively manage complaints.

Recommendations:

1. **Support the ongoing review** of complaint handling processes within the Patient Experience Team and Services to ensure alignment with national standards and improve patient experience metrics.
2. **Encourage further training** and resources for staff to enhance local resolution efforts and improve compliance rates.

3. **Monitor progress** on the implementation of the new factual account template and SPOC initiative to assess their impact on complaint resolution efficiency.

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
- Discussion

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 60% by 31st March 2025)

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

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model
- MS Forms Questionnaires / Surveys

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups / Lived Experience groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
    - Shadowing / observation
    - Walkarounds
    - 15 step challenge

IMPROVING THE EXPERIENCE

It is important to analyse the data, identifying themes and any issues:

- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
    - Framework
    - Leadership
    - Education and training
- Engage staff, patients, families, and carers in improvement work

2.3 Assessment

Stage 1 Complaints, Concerns and Enquiries

To enhance the efficiency within the Patient Experience Team, a new single point of contact (SPOC) has been assigned for each Directorate. This SPOC will streamline the process by ensuring that all new complaints, concerns, and enquiries are directed

to it for prompt distribution. This change is expected to reduce the delays previously experienced when using separate distribution lists for each Directorate or Service

Some concerns were raised within the Acute Directorate regarding the SPOC process and the onward receipt of the complaint. To address this, steps have been taken to ensure the efficient management of complaints and a new email rule was created from the SPOC generic email account, which will automatically forward an email to specific recipients. Additionally, an alert email will be created from Datix to specific recipients when a Stage 2 is created, similar to the incident module. All major or extreme complaints will still be appropriately escalated within the organization to relevant individuals via a separate email alert and sent to the SPOC as new complaints.

The target timeframe for Stage 1 complaints is 80%. In September 2024, there were 37 Stage 1 complaints received, with 39 closed. Of the 39 closed, 19 (48.7%) were closed within timescales (5 working days or 10 working days if an extension has been authorised). Thirty-three complaints were due in the month and were closed on time, which is a compliance of 51.5%.

All Services are reminded of the importance of the local resolution of Stage 1 complaints within the five working day timeframe and with a direct dialogue between the Services and the Complainant. This proactive approach to complaint resolution helps achieve the 80% target timeframe and is crucial in maintaining a high level of patient experience and satisfaction. The terminology has also been changed on Datix to reflect the focus on “Verbal Resolution” and away from “Awaiting Statements”.

All Services have been reminded of the significant benefits local resolution 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.

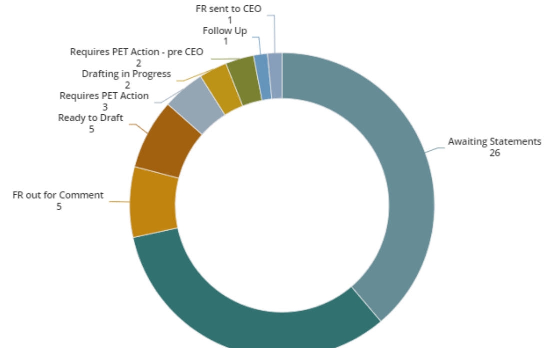
There were 84 open Stage 1’s in total across the 3 months in Q2 compared to 145 in Q2 in 2023/24 which is a 24% reduction. There continues to be a targeted focus of work on reducing the number of open Stage 1’s, concerns, and enquiries. At the start of Quarter 2, there were 35 open Stage 1s, 61 concerns, and 35 enquiries. This increased in August 2024 to 34 open Stage 1s, 74 concerns, and 48 enquiries. At the start of Quarter 3, there has been a significant reduction in all three, with 16 open Stage 1’s, 24 concerns and 8 enquiries this. This is an improvement reduction of 36% for open Stage 1’s, 61% for concerns and 77% for enquiries.

Stage 2’s Complaints

The Complaints Dashboard provides a level of detail that clarifies where each complaint is in the Complaint Handling Procedure. Additional fields have been incorporated into Datix to emphasise and prioritise complaints that necessitate specific actions by the Patient Experience Team. For instance, a new field, “Requires PET Action – pre-CEO,” has been introduced to streamline and enhance this part of the process, ensuring that these complaints receive prompt attention.

The Patient Experience Team are also Collaborating with the Datix team to implement a feature that automatically calculates the number of days taken for the Patient Experience Team to draft a response. Currently, this calculation is done manually, which is inefficient and time-consuming.

Data taken from the second week in October 2024 shows there are 67 stage 2 complaints with the following delays in the process:



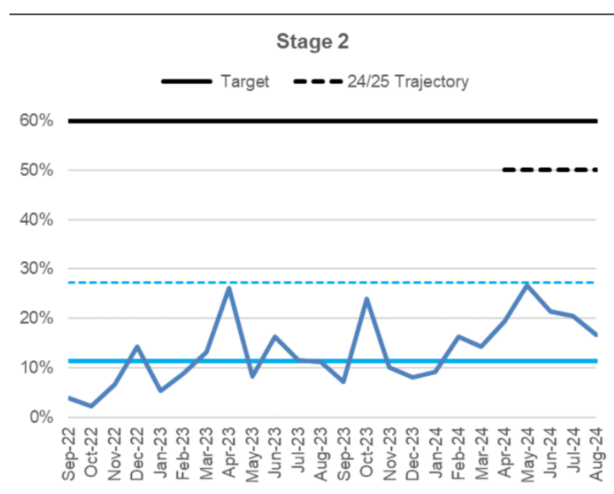
- Awaiting statements – 26 (39%)
- Final response out for comment or approval – 27 (40%)
- Ready to draft, drafting in progress – 7 (10%)
- Requires PET action or follow up – 6 (9%)
- Final Response sent to CEO – 1 (1%)

In September 2024, 33 Stage 2 were complaints received, all acknowledged within the three working day timescale, with 27 closed. There were 35 complaints due in the month and closed on time, which is a compliance of 25.7%. Five of the new Stage 2 complaints were escalated from Stage 1 complaints due to noncompliance with the 5-10 working day timeframe or the complainant was unhappy with the complaint outcome.

There are currently three Stage 2 complaints over 100 days, one awaiting sign-off by the Chief Executive and one with the Service at the final response for approval. The other is an outlier at 263, which involved a SAER and is currently with the Service for comment. There are 18 Stage 2 complaints between 50 and 100 days, with 16 (89%) awaiting action from the Service, 2 (11%) with the Patient Experience Team, one awaiting action and one ready to draft.

In Q2 there were 205 open stage 2 complaints across the 3 months, compared to 483 in Q2 in 2023/24 which is a 58% reduction. At the end of September 2024, the average number of days to close a Stage 2 complaint was 44 days, the lowest it has been in 2024/25. This is a 53% improvement on the average days to close compared to September 2023/24 which was 94 days.

Although frustratingly not meeting the 60% target compliance for Stage 2's closed within 20 days, the chart opposite does show a significant improvement, with seven points above the median since February 2024.



The table below illustrates an improvement in compliance within the 20-day timeframe, showing that 11 out of the last 13 months in 2023/24 have exceeded compliance levels from the previous year.

Stage 2		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
NHS Fife	Closed in Month	28	25	40	25	22	37	21	31	15	28	44	30	27
	Average Closed in Days	94	72	119	82	78	94	76	70	52	57	48	52	44
	Closed on time	2	6	4	2	2	6	3	6	4	6	9	5	7
	% Closed on time	7.1%	24.0%	10.0%	8.0%	9.1%	16.2%	14.3%	19.4%	26.7%	21.4%	20.5%	16.7%	25.9%
	Previous Year	3.8%	2.2%	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%	11.5%	11.1%	7.1%
	Open	113	109	86	71	55	57	62	60	82	79	59	63	64
Acute Services	Closed in Month	16	18	14	17	16	22	10	22	6	23	31	24	20
	Closed on time	1	5	2	1	2	6	2	6	2	5	8	5	5
	% Closed on time	6.3%	27.8%	14.3%	5.9%	12.5%	27.3%	20.0%	27.3%	33.3%	21.7%	25.8%	20.8%	25.0%
HSCP	Closed in Month	12	6	15	8	6	15	11	9	9	5	13	6	7
	Closed on time	1	0	2	1	0	0	1	0	2	1	1	0	2
	% Closed on time	8.3%	0.0%	13.3%	12.5%	0.0%	0.0%	9.1%	0.0%	22.2%	20.0%	7.7%	0.0%	28.6%

A new "factual account 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 factual account template aims to improve the quality of the complaint response and support the completion more promptly.

Scottish Public Services Ombudsmen (SPSO)

In Q1, eight new SPSO cases were received, five decisions, one case was upheld, one case not upheld, and 3 cases were not taken forward.

At the start of October 2024 there are currently 18 open SPSO cases. Ten are with the SPSO for review, six are with the service for review and comment and the remaining two are with the Patient Experience Team for action. The SPSO have implemented a Support Intervention Policy (SIP) for cases that are delayed. There are currently two cases with a SIP-1, two cases with a SIP-2, one case with a SIP-3 and one case with

a SIP-4. The Head of Patient Experience, Patient Experience Lead and Senior Administrator now meet weekly to review and escalate cases.

Patient Experience are liaising with SPSO and NHS Fife Digital and Information to implement Objective Connect system which will allow healthcare records and complaint file to be transferred securely and electronically to the SPSO.

Additional fields have been added to Datix to provide data regarding SPSO status of complaints. Discussion continues regarding this information being added to the Complaint Dashboard.

Care Opinion

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.

The Patient Experience Team are in the process of recruiting 4 Volunteers to support the promotion and gathering of patient stories. The plan will be to focus on hearing patients' stories from those that are currently not being heard, specifically targeting, and engaging with minority communities, children and adolescents, and individuals facing mental health challenges. In addition, the Patient Experience Team will support and promote Care Opinion within services that have not yet engaged with it.

The Quarter 2 report was extremely positive. From July to September 2024, NHS Fife received 386 stories (a 29% increase from 299 stories in 203/24) from members of the public, 83% were completely positive, with the remaining having some level of criticality. These stories received 484 responses from staff and have been read more than 32,538 (a 60% increase from 20,325 times in 2023/24).

For NHS Fife's Community Services, covered as part of a subscription with the HSCP 247 (an 425% increase from 47 stories in 2023/24) members of the public shared their stories about NHS Fife Community Services, 91% of these stories were completely positive, they received 307 responses from staff and these stories have been read more than 11,521 times (a 398% increase from 2,310 times in 2023/24).

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	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied.	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,	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

	an insignificant amount of residual risk or none at all.	There remains a moderate amount of residual risk.	which requires further action to be taken.	

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. Understanding common complaint points from patient feedback can lead to reduced waiting times and improved operational efficiency through streamlined processes and reduced wait times. 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. Insights from complaints can lead to the development of preventive health measures, reducing the incidence of diseases. 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 underserved communities.

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.

By analysing data from patient experience feedback, the organisations can make informed decisions to enhance the quality of care and services. Integrating the principles of realistic medicine, such as shared decision-making and personalized 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 four 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

Update from Patient Experience Team.

2.4 Recommendation

The Committee is asked to take a **“moderate”** level of assurance from the report.

3 List of appendices

- Appendix 1 – Patient Experience & Feedback Quarterly Report (Q1)
- Appendix 2 – Patient Experience Flashcard (Q2)

Report Contact

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Patient Experience and Feedback

PEaF Quarterly Report (Q2) for Clinical Governance Committee

July - September 2024

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Published Month Year

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www.nhsfife.org

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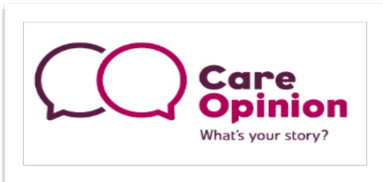
Introduction

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

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 Boards in Scotland.

NHS Fife's **Care Opinion** highlights for Q2 include:

- **607** stories, viewed **46,732** times in all:
  - July 161 stories
  - August 208 stories
  - September 238 stories

In Q4, Care Opinion moderators rated the stories as:

- Not critical 87% (526)
- Minimally critical 3% (22)
- Mildly critical 9% (56)
- Moderately critical 1% (3)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made. Four Care Opinion stories were published where a change within a service was identified.

Positive and Negative Themes

What was good?

What could be improved?

Compliments:

'Compliments', another vital component of patient feedback, is not routinely reported on. There is a 'compliments' section in the Datix Complaints module, which is not widely used, and the following table only provides a small glimpse of positive patient feedback. Many Services collect their own feedback; MS Forms questionnaires, paper feedback forms etc.

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 Q3	23/24Q4	24/25 Q1	24/25 Q2	Total
Compliment	277	263	302	306	1148
Learning from Excellence	0	0	0	0	0
Comments and Feedback	0	0	3	3	6
Total	277	263	305	309	1154

Compliments	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	Total
Acute Services Division - Planned Care & Surgery	127	76	133	150	486
Acute Services Division - Emergency Care & Medicine	37	32	45	50	164
Acute Services Division - Women, Children and Clinical Services	10	40	23	6	79
Community Care Services	59	37	37	35	168
Primary and Preventative Care Services	27	27	29	28	111
Complex and Critical Care Services	7	6	7	8	28
Corporate Directorates	1	0	0	1	2
No value - Miscellaneous	9	45	28	28	110
Total	277	263	302	306	1148

Comments:

Primary & Preventative Care Services - Thank you for your help, support, kindness, tissues and generally just 'getting it' you have no idea how much it means to have people like you supporting stroke recovery. The mental support has been just as important as the professional support."

Community Care Services – "Probably you have heard by now, X passed away yesterday afternoon. Palliative care support was very good, he was undistressed and surrounded by his family.

You were exceptional in your support these past months and we appreciated how kind and cheery you were with him.

Complex & Critical Care Services - Thank you so much for all you have done for my Dad. You have been amazing.

Complaints:

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution

The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.

Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation

Complaints might be handled at stage 2 because:

- They are complex, serious or high-risk issues and are not suitable for early resolution
- early resolution has failed
- the complainant was unhappy with the outcome of stage 1 and asked for an investigation.

The complainant should receive a written response within 20 working days.

This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 01/06/2023 - 30/06/2024	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	Total
Stage 1 Complaint	129	113	142	116	**500**
Stage 2 Complaint	56	65	79	82	**282**
Concern	121	241	162	175	**699**
Enquiry	163	131	111	103	**508**
Total	**469**	**550**	**494**	**476**	**1989**

Stage 2 closed complaints and % closed within the 20-day standard timescale.

COMPLAINTS DUE	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total	29	21	13	15	23	19	26	23	33	33	22	35
Closed within timescales	5	6	0	2	4	3	6	3	7	5	4	9
% Closed within timescales	17.2%	28.6%	0.0%	13.3%	17.4%	15.8%	23.1%	13.0%	21.2%	15.2%	18.2%	25.7%

Themes

The quarterly ranking of each theme is highlighted in brackets.

	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2
1	Co-ordination of clinical treatment (49)	Disagreement with treatment / care plan (30)	Disagreement with treatment / care plan (41)	F5133 Disagreement with treatment / care plan (51)
2	Disagreement with treatment / care plan (44)	Co-ordination of clinical treatment (19)	Co-ordination of clinical treatment (34)	F5115 Co-ordination of clinical treatment (35)
3	Staff attitude (31)	Face to face (11)	Staff attitude (9)	A0502 Face to face (10)
4	Unacceptable time to wait for the appointment / admission (15)	Lack of clear Explanation (8)	Face to face (5)	A0103 Staff attitude (7)
5	Insensitive to patient needs (13)	Staff attitude (8)	Accuracy of records (5)	A0504 Lack of a clear explanation (7)

These complaint issues have been addressed at a local level, but Organisational learning must take place to improve practice and the patient experience.

Locations receiving most complaints:

1. Mental Health (20)
2. Obstetrics & Paediatrics (18)
3. General Medicine (14)
4. General Surgery (11)
5. Front Door (10)

Improving the Experience

Surveys, Focus Groups, Care Assurance Processes

Each quarter, this section will include feedback from patient / family surveys, complainant survey, patient and staff focus groups, and care assurance processes, including leadership walkarounds; 15 steps challenge; shadowing / observation; 'warm welcome / fond farewell' initiative; care experience improvement model.

'Welcome Poster' is an initiative to standardize Ward/Department information, outlining expected commitments and NHS Scotland Uniforms. Poster has recently been reviewed and updated.

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 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	2022/ 2023	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	2024/ 2025
New SPSO cases	8	7	8	7	30	7	7			14
SPSO decisions	5	0	3	1	9	3	5			8
SPSO cases upheld	1	0	2	1	4	1	1			2
SPSO cases not upheld	1	0	1	0	2	N/A	N/A			N/A
Cases not taken forward	3	0	1	6	10	2	4			6

New SPSO cases this quarter

This quarter, 7 new information requests have been received. These relate to the following services:

- Surgical Directorate: 1
- Medical Directorate: 6

Support and intervention Policy (SIP) - SIPLeaflet.pdf

- This quarter, 7 SPSO complaints had a Support and Intervention Policy applied:
- SIP Level 1 - 2
- SIP Level 2 – 2
- SIP Level 3 – 1
- SIP Level 4 – 1
- SIP Level 5 - 0

NHS Scotland Model Complaints Handling Procedure

Introduction

Empowering people to be at the centre of their care and listening to them, their carers' and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- to take a consistently person-centred approach to complaints handling across NHS Scotland
- to implement a standard process
- to ensure that NHS staff and people using NHS services have confidence in complaints handling
- encourage NHS organisations to learn from complaints 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.

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:

A patient was admitted following a fall and left-sided pneumonia, during which several critical issues arose, particularly regarding the diagnosis of a hip fracture. Key findings include:

- ***Missed Diagnosis Opportunities:*** *There were multiple missed opportunities to diagnose the patient's hip fracture, as the local protocol designed for suspected fractures was not followed. This highlights the need for a thorough review and distribution of the protocol to all staff to improve compliance.*
- ***Inadequate Pain Assessment:*** *Pain assessment was not documented robustly, indicating the necessity for implementing standardized pain assessment protocols to ensure accurate evaluation and management.*
- ***Communication Gaps:*** *Communication between the multidisciplinary team (MDT) needs improvement, particularly concerning the patient's decline in mobility. This information should be included in daily board rounds to prompt timely reviews of the patient's condition.*
- ***X-Ray Results Reconciliation:*** *A results reconciliation process should be established to ensure that teams are aware when x-ray reports are available. This will facilitate timely review and necessary actions based on the findings.*
- ***Role of Delirium:*** *The presence of delirium may have affected the patient's ability to communicate her pain effectively, complicating the diagnosis and treatment process.*
- ***Diabetic Medication Communication:*** *The cessation of the patient's diabetic medications was appropriately managed but not communicated during transitions in care, leaving the family unaware of these changes.*
- ***Readmission Factors:*** *The patient was later readmitted with Hyperosmolar Hyperglycaemic State (HHS) due to a catheter-associated urinary tract infection, which was determined not to be related to the discontinuation of their diabetes medications.*

Key Learning:

- ***Protocol Adherence:*** *Strict adherence to clinical protocols is vital for timely and accurate diagnoses. Regular training and distribution of protocols can enhance compliance among staff.*
- ***Robust Pain Assessment:*** *Implementing standardized pain assessment documentation is essential for effective pain management and ensuring that all patient needs are addressed.*
- ***Enhanced MDT Communication:*** *Improving communication in the MDT, particularly regarding mobility changes, is crucial for patient monitoring and care continuity.*
- ***Results Reconciliation Process:*** *Establishing a results reconciliation process will help ensure that critical information, such as x-ray results, is reviewed promptly and acted upon.*

These insights highlight the importance of systematic improvements in communication, adherence to protocols, and comprehensive patient assessments to enhance patient safety and overall quality of care. Duty of Candour was activated.

A patient underwent laparoscopic left salpingo-oophorectomy (LSO) and sterilization, during which two small lesions were observed on her right inner thigh post-operatively. Despite the use of a Caiman bipolar energy device, the cause of the lesions remains unclear. Possible explanations include accidental contact from Vulsellum forceps used during the procedure. The patient experienced ongoing pain and distress, and the issue was raised to NHS Fife three months later.

Key Learning:

- ***Documentation and Communication:*** *The theatre gynaecology care plan noted a reddened area on the patient's thigh, but it is unclear when this was observed. Improved documentation and handover communication between the operating team, theatre recovery, and post-operative ward are essential to ensure all team members are aware of skin changes.*
- ***Patient Discharge Process:*** *The discharge letter to the General Practitioner did not mention the skin changes. This highlights the need for thorough communication regarding all post-operative findings and ensuring that patients' concerns are addressed before discharge.*

- ***Importance of Listening to Patients:*** *Actively listening to and addressing patient concerns post-operatively is critical for their care and satisfaction.*
- ***Incident Reporting:*** *The skin changes should have been reported on DATIX within 24 hours, in accordance with NHS Fife's Adverse Events Policy. Timely reporting is crucial for proper follow-up and support for the patient.*
- ***Preventative Measures:*** *While the exact cause of the lesions is unknown, safe surgical practices will remain a priority. The use of Vulsellum forceps to clamp across a Foley catheter will be discouraged, and a tube organizer will be recommended instead. This incident will be shared widely among theatre teams to promote learning and prevent recurrence.*

These insights emphasize the importance of thorough documentation, effective communication, and attentiveness to patient feedback in surgical settings to enhance patient safety and care quality. Duty of Candour was not activated.

A 12-year-old boy experiencing severe abdominal pain and vomiting suspected to be testicular torsion, was taken to the Emergency Department (ED) after calling NHS 24. The parent expressed dissatisfaction with several aspects of the care received:

- ***Delay in Decision-Making****: There was a significant delay in determining whether their son should be transferred to the Royal Hospital for Children and Young People for surgery or treated at NHS Fife. The parent felt this was unacceptable given the urgency of the condition.*
- ***Separation During Transport****: Initially, the parent was informed that their son would be transported by ambulance alone, and she would have to follow in her own car. This was distressing for both the parent and the child.*
- ***Surgical Delay:*** *After surgery, the parent learned that the procedure could have been performed in NHS Fife, and the delay in treatment resulted in jeopardised functionality of the affected testicle.*
- ***Inadequate Pain Management:*** *The child was reportedly left in significant pain with minimal pain relief provided prior to the transfer.*

Key Learning:

- ***Investigation Findings:*** *A miscommunication regarding treatment pathways for children under 13 with suspected testicular torsion led to the delays. The ED believed patients aged 12 and over should be treated in NHS Fife, and no formal agreement existed for children under 13.*
- ***Acknowledgment of Mistakes:*** *The responding medical professionals recognised that adequate pain relief was not administered before transfer and that the suggestion for the child to travel alone was inappropriate.*
- ***Changes Implemented:*** *Following the complaint, the pathway for treating suspected testicular torsion in boys aged 11 and older has been clarified, ensuring they are treated in a timely manner in the appropriate facility.*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided. NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *The Patient Experience Team are holding quarterly meeting to review feedback data more frequently and effectively. During these meetings, thematic analysis of the feedback received will be conducted, allowing the identification of recurring issues and trends. This structured approach will enable the Patient Experience Team to implement targeted quality improvement initiatives aimed at enhancing the complaint handling procedure. With the ultimate goal to improve the patient experience, ensuring that individuals feel heard and supported throughout the complaints process. Report of themes and improvement initiatives will feature in future reports.*

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q1	0	55		Figures provided for NHS, Social work / Fife Council, Voluntary Sector – Good Conversations training did not take place in Q2 due to vacancy in post.
	Q2	0	0		
	Q3				
	Q4				
Gc half- day intro course	Q1	16	0		Good Conversations training did not take place in Q2 due to vacancy in post.
	Q2	0	0		
	Q3				
	Q2				
Gc Foundation Management		0			
Human Factors	16				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 Training	Q1	125			
	Q2	127			
	Q3				
	Q4				

Indicator Four: The total number of complaints received

	Q3	Q4	Q1	Q2	Total
4a. Number of complaints received by the NHS Fife Board	236	233	221	198	**888**
4b. Number of complaints received by NHS Primary Care Service Contractors	106	N/A	N/A	N/A	**106**
4c. Total number of complaints received in the NHS Board area	**342**	**233**	**221**	**198**	**994**

Records logged in Datix Complaints module – 01/06/2023 - 30/09/2024	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	Total
Stage 1 Complaint	129	113	142	116	**500**
Stage 2 Complaint	56	65	79	82	**282**
Concern	121	241	162	175	**699**
Enquiry	163	131	111	103	**508**
Total	**469**	**550**	**494**	**476**	**1989**

NHS Fife Board - sub-groups of complaints received -

	Q3	Q4	Q1	Q2	Total
4d. General Practitioner	2	1	1	3	**7**
4e. Dental	0	1	1	0	**2**
4f. Ophthalmic	0	0	0	0	**0**
4g. Pharmacy	0	0	0	0	**0**
Total - Board managed Primary Care services	**2**	**2**	**2**	**3**	**9**

	Q3	Q4	Q1	Q2	Total
4h. General Practitioner	81	90	N/A	N/A	**171**
4i. Dental	7	1	N/A	N/A	**8**
4j. Ophthalmic	0	N/A	N/A	N/A	**0**
4k. Pharmacy	18	N/A	N/A	N/A	**18**
Total – Independent Contractors	**106**	**91**	**N/A**	**N/A**	**197**
4l. Combined total of Primary Care Service complaints	**108**	**93**	**2**	**3**	**206**

Indicator Five: Complaints closed at each stage

Number of complaints closed by the NHS Board *(do* *not include contractor data, withdrawn cases or cases where consent not received).*	**Number**				**As a % of all NHS Fife complaints closed (not contractors)**			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
5a. Stage One	140	122	126	115	76%	80%	70%	72%
5b. Stage two – non escalated	36	22	44	36	20%	15%	25%	22%
5c. Stage two - escalated	7	8	9	9	4%	5%	5%	6%
5d. Total complaints closed by NHS Board	**183**	**152**	**179**	**160**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld, and not upheld -

Stage one complaints	**Number**				**As a % of all complaints closed by NHS Fife at stage one**			
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
6a. Number of complaints upheld at stage one	83	42	28	32	52%	31%	19%	28%
6b. Number of complaints not upheld at stage one	46	69	79	51	28%	50%	54%	44%
6c. Number of complaints partially upheld at stage one	32	26	38	32	20%	19%	26%	28%
6d. Total stage one complaints outcomes	**161**	**137**	**145**	**115**	**100%**	**100%**	**100%**	**100%**
	Number				**As a % of all non-escalated**			

Stage two complaints **Non-escalated complaints**					**complaints closed by NHS Fife at stage two**			
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
6e. Number of non-escalated complaints **upheld** at stage two	14	7	14	9	32%	22%	27%	32%
6f. Number of non-escalated complaints **not upheld** at stage two	18	19	25	11	42%	59%	49%	39%
6g. Number of non-escalated complaints **partially upheld** at stage two	11	6	12	8	26%	19%	24%	29%
6h. Total stage two, non-escalated complaints outcomes	**43**	**32**	**51**	**28**	**100%**	**100%**	**100%**	**100%**
Stage two escalated complaints **Escalated complaints**	**Number**				**As a % of all escalated complaints closed by NHS Fife at stage two**			
	Q3	Q4	Q1	Q2	**Q3**	**Q4**	**Q1**	**Q2**
6i. Number of escalated complaints **upheld** at stage two	1	0	2	1	14%	0%	17%	10%
6j. Number of escalated complaints **not upheld** at stage two	5	11	6	8	72%	92%	50%	80%
6k. Number of escalated complaints **partially upheld** at stage two	1	1	4	1	14%	8%	33%	10%
6l. Total stage two escalated complaints outcomes	**7**	**12**	**12**	**10**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times -

	Q3	**Q4**	**Q1**	**Q2**
7a. the average time in working days to respond to complaints at stage one	12	12	12	9
7b. the average time in working days to respond to complaints at stage two	50	52	37	31
7c. the average time in working days to respond to complaints after escalation	78	63	51	18

Indicator Eight: Complaints closed in full within the timescales -

	Number				**As a % of complaints closed by NHS Fife at each stage**			
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
8a. Number of complaints closed at stage one within 5 working days.	62	58	59	56	86%	86%	79%	77%
8b. Number of non-escalated complaints closed at stage two within 20 working days	7	7	14	11	10%	10%	19%	15%
8c. Number of escalated complaints closed at stage two within 20 working days	3	3	2	6	4%	4%	2%	8%
8d. Total number of complaints closed within timescales	**72**	**68**	**75**	**73**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorised-

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
9a. Number of complaints closed at stage one where extension was authorised	47	18	15	10	69%	56%	65%	63%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	21	14	8	6	31%	44%	35%	37%
9c. Total number of extensions authorised	**68**	**32**	**23**	**16**	**100%**	**100%**	**100%**	**100%**

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

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

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

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Hayfield Road
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Patient Experience Flashcard

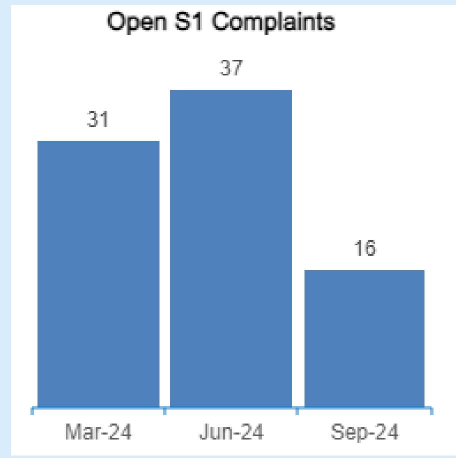
October 2024

S1 Complaints Performance

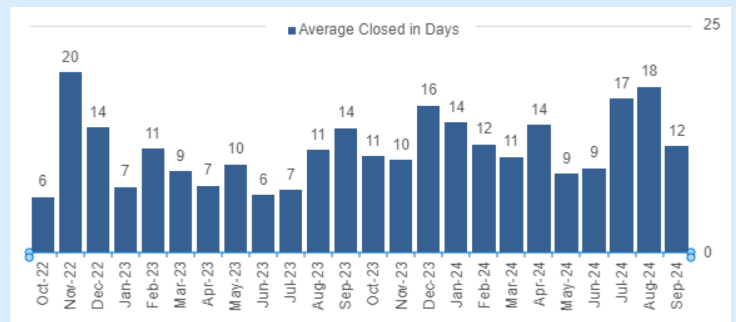
Target Compliance – 80%

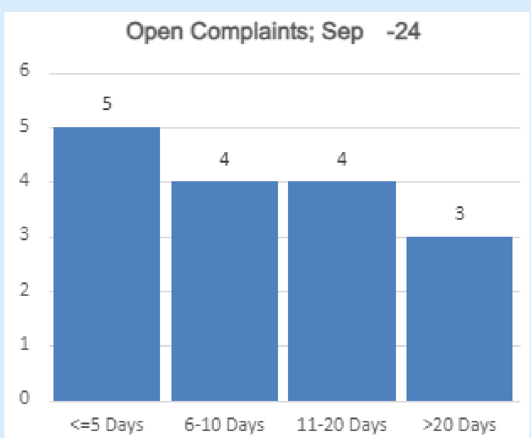
Records logged in Datix Complaints module – 01/06/2023 - 30/06/2024	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	Total
Stage 1 Complaint	139	129	113	142	523
Stage 2 Complaint	87	56	65	79	287
Concern	131	121	241	162	655
Enquiry	210	163	131	111	615
Total	567	469	550	494	2080

S1 Opened Complaints



Closed S1 Complaints - % Closed within Timescales

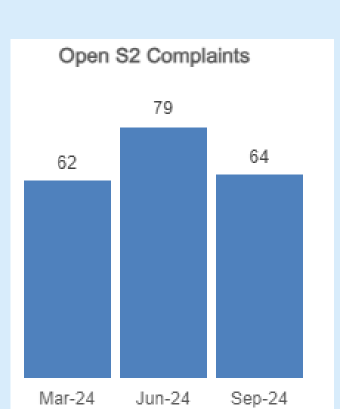


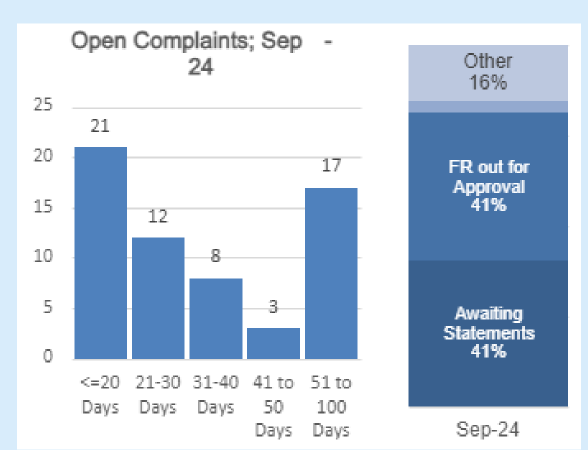


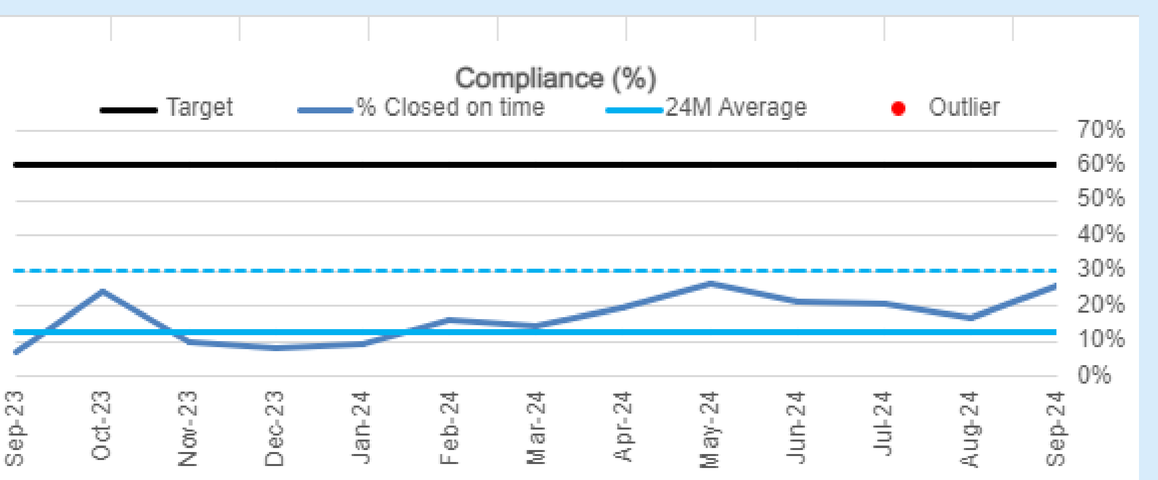
Stage 1		2022/23				2023/24								
		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
NHS Fife	Opened in Month	48	40	52	41	41	47	35	50	56	51	36	59	37
	Closed in Month	42	42	52	41	37	45	33	47	46	45	37	56	39
	Average Closed in Days	14	11	10	16	14	12	11	14	9	9	17	18	12
	Closed on time	23	23	39	18	23	24	11	16	23	31	22	28	19
	% Closed on time	54.8%	54.8%	75.0%	43.9%	62.2%	53.3%	33.3%	34.0%	50.0%	68.9%	59.5%	50.0%	48.7%
	Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
	Previous Year	78.0%	70.0%	45.5%	54.1%	62.9%	50.0%	63.6%	56.5%	40.4%	65.0%	71.8%	42.6%	54.8%

Stage 1		2022/23				2023/24								
		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Acute Services	Closed in Month	26	32	52	26	19	31	33	47	31	35	25	36	25
	Closed on time	14	20	39	13	11	18	11	16	11	26	15	20	13
	% Closed on time	53.8%	62.5%	75.0%	50.0%	57.9%	58.1%	33.3%	34.0%	35.5%	74.3%	60.0%	55.6%	52.0%
HSCP	Closed in Month	13	8	16	14	14	13	8	15	14	10	8	15	12
	Closed on time	8	3	14	4	10	6	1	6	11	5	6	6	5
	% Closed on time	61.5%	37.5%	87.5%	28.6%	71.4%	46.2%	12.5%	40.0%	78.6%	50.0%	75.0%	40.0%	41.7%

S2 Complaints Performance – Target Compliance – 60% by March 2025







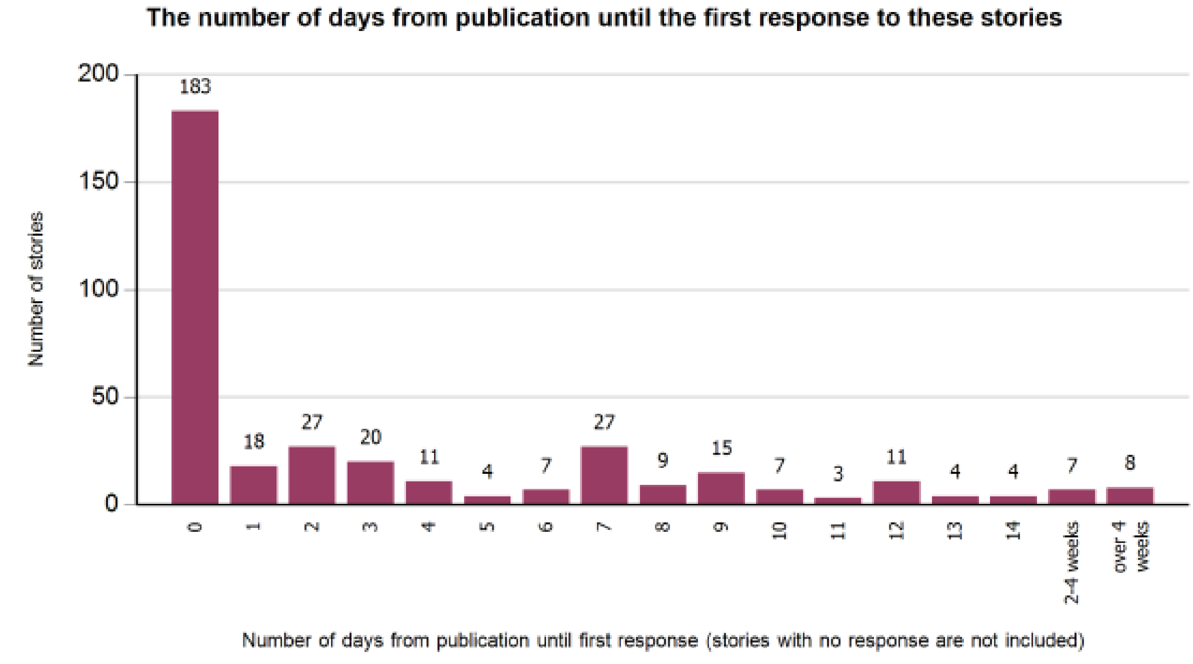
Stage 2		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
NHS Fife	Opened in Month	30	26	17	14	25	20	22	25	34	29	25	33	33
	Acknowledged on time	30	24	17	14	20	20	21	24	34	26	25	33	33
	% Acknowledged on time	100.0%	92.3%	100.0%	100.0%	80.0%	100.0%	95.5%	96.0%	100.0%	89.7%	100.0%	100.0%	100.0%

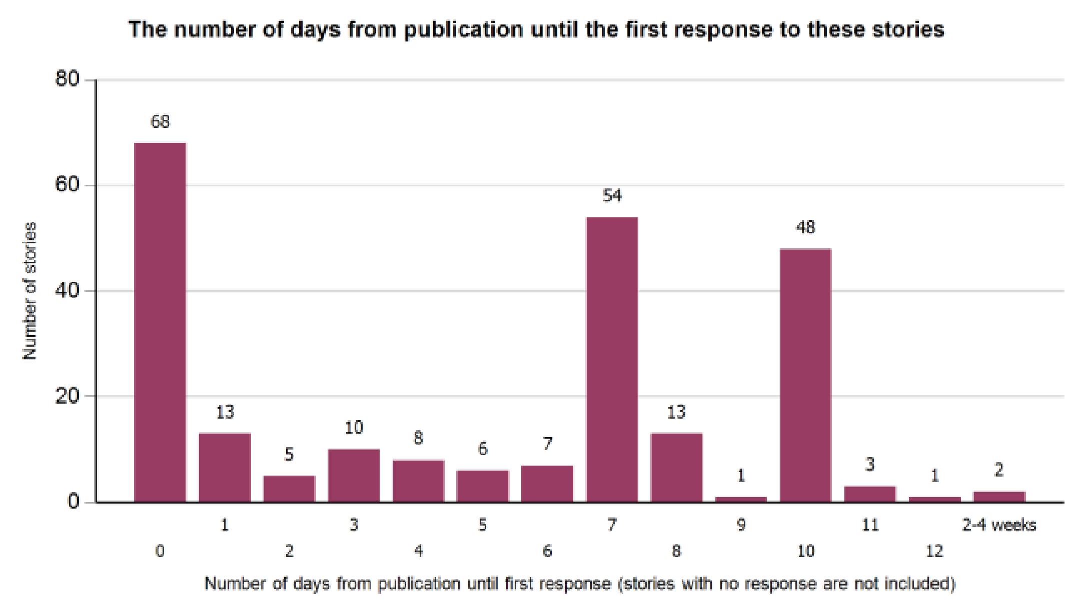
Stage 2		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
NHS Fife	Closed in Month	28	25	40	25	22	37	21	31	15	28	44	30	27
	Average Closed in Days	94	72	119	82	78	94	76	70	52	57	48	52	44
	Closed on time	2	6	4	2	2	6	3	6	4	6	9	5	7
	% Closed on time	7.1%	24.0%	10.0%	8.0%	9.1%	16.2%	14.3%	19.4%	26.7%	21.4%	20.5%	16.7%	25.9%
	Previous Year	3.8%	2.2%	6.7%	14.3%	5.3%	8.8%	13.2%	26.1%	8.3%	16.2%	11.5%	11.1%	7.1%
	Open	113	109	86	71	55	57	62	60	82	79	59	63	64
Acute Services	Closed in Month	16	18	14	17	16	22	10	22	6	23	31	24	20
	Closed on time	1	5	2	1	2	6	2	6	2	5	8	5	5
	% Closed on time	6.3%	27.8%	14.3%	5.9%	12.5%	27.3%	20.0%	27.3%	33.3%	21.7%	25.8%	20.8%	25.0%
HSCP	Closed in Month	12	6	15	8	6	15	11	9	9	5	13	6	7
	Closed on time	1	0	2	1	0	0	1	0	2	1	1	0	2
	% Closed on time	8.3%	0.0%	13.3%	12.5%	0.0%	0.0%	9.1%	0.0%	22.2%	20.0%	7.7%	0.0%	28.6%

Acute

In **Q2**, **NHS Fife** received **386** stories on Care Opinion from Patients, Relatives, Carers, Friends and staff posting on behalf of patients about acute/ secondary services, which is an increase of **29%** from the previous year (**299** in **2023/24**).

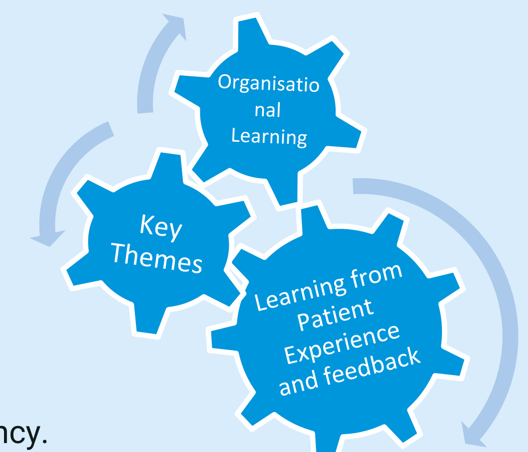
83% of the stories told were completely positive with the remaining **17%** having some level of criticality. Staff and services responded to these stories **484 times** and have been read more than **32,538** times so far (a **60%** increase from **20,325** times in **2023/24**).





In **Q2 H&SCP** received **247** stories on Care Opinion from Patients, Relatives, Carers, Friends and staff posting on behalf of patients about acute/ secondary services, which is an increase of **425%** from the previous year (**47** in **2023/24**).

91% of the stories told were completely positive with the remaining **9%** having some level of criticality. Staff and services responded to these stories **307 times** and have been read more than **11,521** times so far (a **398%** increase from **2,310** times in **2023/24**).



PATIENT EXPERIENCE UPDATES

- **New Single Point of Contact (SPOC)**: Streamlines complaint handling process across Directorates.
- **Local Resolution Emphasis**: Encourages resolving complaints directly to enhance patient satisfaction and reduce workload.
- **Improvement**: Significant reduction in open Stage 1complaints from Q2 to Q3, showcasing improved efficiency.
- **Quality Assurance**: New factual account template improves response quality and reduces redundancy.
- **Performance:** September 2024 saw 37 Stage 1 complaints received, with 39 closed.
- **Performance:** Compliance within timescales for Stage 1 complaints was at 48.7%; overall compliance was 51.5%.
- **Performance:** 67 S2 complaints with various delays in processing.
- **Performance:** September 2024 saw 33 Stage 2 complaints received, with a 25.7% compliance rate for timely closures.
- **Performance:** 18 open SPSO cases with 6 Support Intervention Policies.
- **Dashboard Utilisation**: Provides clarity on complaint status with further work required.
- **Challenges**: Not meeting the 60% target for S2 complaints closed within 20 days, although showing improvement trends.
- **Promotion and Training**: Regular support visits to clinical areas to encourage staff engagement with Care Opinion.
- **Volunteer Recruitment**: Aiming to gather diverse Care Opinion patient stories, particularly from underrepresented groups.
- **Positive Outcomes**: Notable increase in Care Opinion patient stories collected during Q2.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Hospital Standardised Mortality Ratio Update Report 2023/24**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance**

Executive Summary:

- This report provides assurance that the Hospital Standardised Mortality Ratio (HSMR) for NHS Fife for the period April 2023- March 2024 remains within limits at 0.96. Value less than one, means the number of deaths is fewer than predicted. Greater than one means the number of deaths is more than predicted.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- National Health & Wellbeing Outcomes / Care & Wellbeing Portfolio
- 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 report provides assurance on the Hospital Standardised Mortality Ratios (HSMR) for NHS Fife including:

- A summary of what HSMR is used for; and
- An overview of HSMR in NHS Fife for the period April 2023 to March 2024.

2.2 Background

HSMR data takes into consideration the factors which are recognised to affect the risk of death. Public Health Scotland (PHS) collate and oversee HSMR data at a national level. The case mix of patients between different hospitals varies and as such the HSMR data is adjusted to allow comparison between hospitals. This approach is more effective than using crude mortality rates as a means of bench marking across Scotland.

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

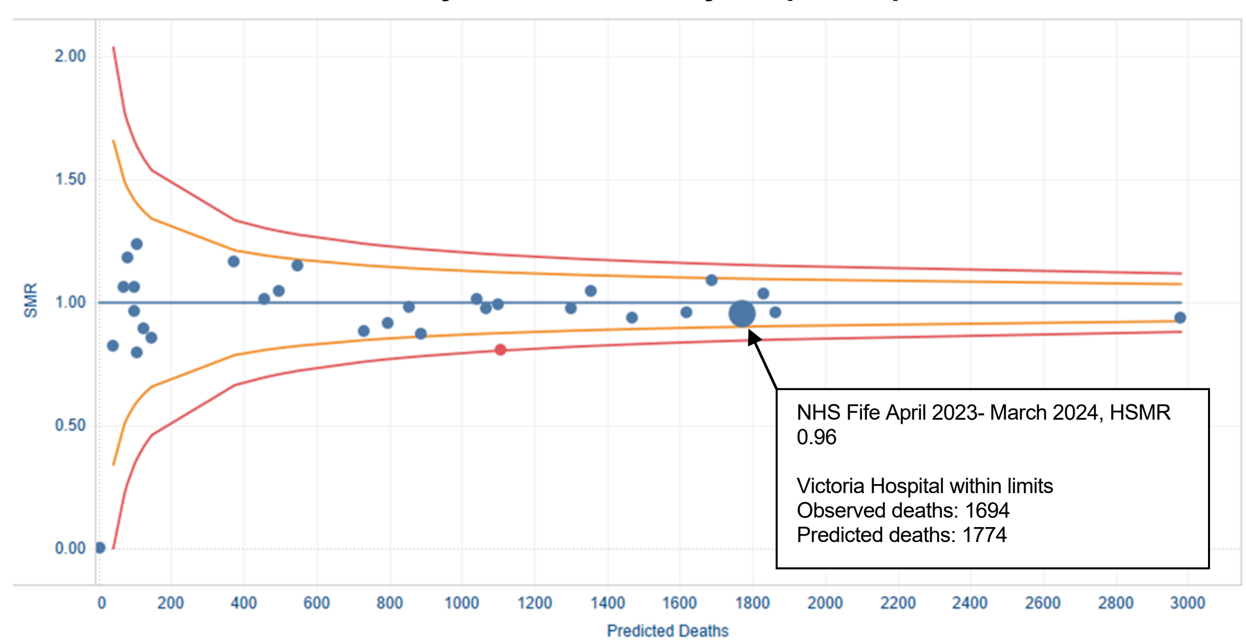
NHS Fife monitors HSMR as one of the key quality performance indicators for safety and quality. HSMR quarterly data is published in the Integrated Performance and Quality Report (IPQR).

2.3 Assessment

HSMR in NHS Fife

The HSMR for NHS Fife during 2023-2024 was 0.96 which provides assurance that the local mortality ratio was at level in keeping with the national average and in keeping with the local HSMR levels (as demonstrated in chart 1).

Chart 1.
HSMR for deaths within 30 days of admission by hospital: April 2023 to March 2024



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

The NHS Fife data for this period is summarised below:

Period	Hospital	Observed Deaths	Predicted Deaths	Patients	HSMR	Crude Mortality Rate (%)
April 2023-March 2024	Victoria Hospital	1694	1774	29267	0.96	5.8

The PHS HSMR report 2023-2024 highlights the following main points, which are largely consistent with the 2022-2023 report:

- No hospitals had a significantly higher or lower standardised mortality ratio than the national average.
- Non-elective admissions consistently account for the largest proportion of deaths within 30-days of admission.
- Patients from the least deprived areas of Scotland consistently have lower levels of crude 30-day mortality than patients from more deprived areas.
- Around 4 in 5 deaths within 30-days of admission take place in hospital while the remaining deaths take place in the community.

The PHS Report 2023-2024 can be accessed via the following link:
Hospital Standardised Mortality Ratio (publichealthscotland.scot)

HSMR Methodology

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

NHS Fife

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 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	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied.	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,	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

	an insignificant amount of residual risk or none at all.	There remains a moderate amount of residual risk.	which requires further action to be taken.	

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

N/A

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

- The Medical Director, 14th October 2024

2.4 Recommendation

The Clinical Governance Committee are recommended to:

- Note the update provided,
- Take a **"moderate"** level of assurance that HSMR is monitored as a key quality performance indicator; and
- Take a **"moderate"** level of assurance that the HSMR for NHS Fife remains within limits.

Report Contact
Gemma Couser
Associate Director of Quality and Clinical Governance
Email gemma.couser2@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting Date:	**1 November 2024**
Title:	**Medical Appraisal and Revalidation Annual Report 2023/2024**
Responsible Executive:	**Dr Chris McKenna, Executive Medical Director, NHS Fife**
Report Author:	**Alison Gracey, Medical Appraisal and Revalidation Coordinator** **Dr Shirley-Anne Savage. Associate Director for Risk and Professional Standards**

Executive Summary

- The General Medical Council requires that all doctors practising in the UK must revalidate their licence to practise every 5 years to provide assurance that they are up to date and practising to the appropriate professional standards.
- Medical appraisal is an integral part of revalidation.
- All doctors in both Primary Care and Secondary Care must participate in annual appraisal, providing evidence of the doctor's range and volume of practise and must include feedback from colleagues and patients at least once during the 5 year period.
- This report outlines the process, governance structure, challenges facing NHS Fife and appraisal/revalidation figures for 2023/2024.
- The report gives assurance that NHS Fife responds well to the challenges of Medical Appraisal and Revalidation, supporting doctors through the process.

1. Purpose

This report is presented for:
- Assurance
- Discussion

This report relates to:
- Annual Delivery Plan

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

2. Report Summary

2.1 Situation

The Medical Staff Revalidation and Appraisal report for 2023-2024 is being brought to the Clinical Governance Committee for their awareness. The report provides the committee with an assurance that doctors in NHS Fife are up-to-date and are practising to the appropriate professional standards.

2.2 Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3 Assessment

NHS Fife responds well to the challenges of Medical Revalidation and Appraisal with few problems and is meeting the requirements of the GMC. There is still a challenge in Secondary Care to recruit and retain sufficient NES Trained Appraisers, however, the required appraisals are being carried out with the help of their current appraisers and a few bank appraisers. Primary Care does not have any issues with recruitment of Appraisers. Secondary Care continues to advertise the role.

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

Medical appraisal ensures that licensed doctors are up-to-date and are practising to the appropriate professional standards.

2.3.2 Workforce

NHS Fife continues to support doctors to meet the GMC requirements with regard to appraisal and revalidation.

2.3.3 Financial

- Not applicable

2.3.4 Risk Assessment / Management

There may be a risk of being unable to meet the GMC requirements for Medical Revalidation and Appraisal if unable to recruit and retain sufficient numbers of NES Trained Appraisers.

2.3.5 Equality and Human Rights, including children's rights, 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

Medical Appraisal and Revalidation reports into the NHS Fife Medical and Dental Professional Standards Oversight Group.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

2.3.8 Route to the Meeting

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

- NHS Fife Medical and Dental Professional Standards Oversight Group

2.4 Recommendation

This paper is provided to Clinical Governance Committee members for:

- **Assurance** – This report provides a **"significant"** Level of Assurance.

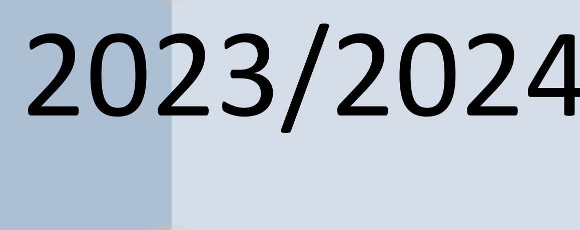
3. List of Appendices

- Appendix 1: Medical Appraisal and Revalidation Annual Report 2023/2024

Report Contact:
Alison Gracey
Medical Appraisal and Revalidation Coordinator
Email alison.gracey@nhs.scot

Medical Appraisal and Revalidation Annual Report

Consultants, Career Grade Doctors and General Practitioners



2023/2024

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Medical Appraisal and Revalidation 2023/2024

Consultants, Career Grade Doctors and General Practitioners

Background

Any doctor wishing to practise medicine in the UK must be registered with the General Medical Council (GMC) and hold a licence to practise which needs to be revalidated every 5 years. This is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

Revalidation requires annual appraisal, including feedback from colleagues and patients at least once during the five year period. Evidence of the doctor's range and volume of practice, such as the number of operations carried out or prescribing patterns is also reviewed.

Governance Structure

Every doctor wishing to practise medicine in the UK must be linked to a Designated Body and its' Responsible Officer (RO) referred to as a "prescribed connection". Recommendations for the revalidation of all doctors is achieved through each Health Board's RO.

NHS Fife meets with representatives of the GMC twice yearly. These meetings cover feedback on actions from the last meeting; GMC and local updates, current GMC cases, closed GMC cases, GMC related press enquiries for NHS Fife doctors and the opportunity for the RO to discuss any other issues such as revalidation.

In line with national policy Dr Chris McKenna is NHS Fife's Responsible Officer, Dr Iain MacLeod and Dr Helen Hellewell are NHS Fife's Deputy Responsible Officers. This responsibility covers all Consultants, Career Grade Doctors and General Practitioners employed by NHS Fife.

Medical Revalidation in NHS Fife was overseen by the Medical Appraisal and Revalidation Group during 2023/24. This group was decommissioned at the end of the 2023/24 period, and going forward the Medical Appraisal and Revalidation will be overseen by the newly convened Medical and Dental Professional Standards Oversight Group, chaired by Dr Chris McKenna, Medical Director/Responsible Officer – NHS Fife. This group reports to NHS Fife's Clinical and Staff Governance Committees.

NHS Fife developed the Medical Appraisal and Revalidation Strategic Framework during 2023/2024 with the purpose of ensuring the delivery of high quality appraisals for all eligible doctors within NHS Fife and to give assurance to the organisation and public that our employed and contracted doctors are professionally up to date and fit to practice medicine.

An annual review of appraisal and revalidation, the Medical Appraisal & Revalidation Quality Assurance (MARQA) Review, is commissioned by the Revalidation Delivery Board for Scotland (RDBS) on behalf of the Scottish Government. The review is facilitated by NHS Education for Scotland (NES). The Chief Medical Officer (CMO) requires Medical Directors of NHS Boards to submit an Annual Report outlining the key performance indicators relating

to the delivery of appraisal to their NHS Board. Submission of the MARQA report would normally suffice for this purpose. MARQA was postponed from 2020 to 2023 due to the Covid pandemic but has been reinstated in 2024 in a slightly reduced format. Following the 2023/24 review, NHS Fife received a letter of thanks confirming that the review panel were reassured that appraisal and revalidation is operating successfully within the organisation.

Annual Appraisal

Revalidation for doctors in Scotland is achieved by using a standardised bespoke "Enhanced Appraisal" system designed by the National Appraisal Leads Group for Scotland (NALG).

All doctors in both Primary Care and Secondary Care are required to participate in an annual appraisal.

Appraisals are documented using the NHS Education Scotland (NES) provided web based system SOAR (Scottish Online Appraisal Resource). A signed Form 4 (appraisal summary) is proof that an individual has successfully engaged in the Appraisal process for that year.

Appraisers

All appraisers in Scotland must be NES trained. In Primary Care there are 14 NHS Fife appointed NES trained Appraisers. This allows every General Practitioner (GP) to have an annual appraisal. GP Appraiser recruitment is undertaken locally. GP appraisers are expected to undertake around 18 appraisals per annum for 1 session.

The number of NES trained appraisers in Secondary Care continues to fluctuate and as at 31 March 2024, having lost and recruited appraisers throughout the year, was 45 including 4 bank appraisers. Four of the total number of appraisers cover Clinical Fellow appraisals only and a further 2 are employed by St Andrew's University and cover their Medical Demonstrators.

Appraisers in Secondary Care are expected to cover 10 appraisals per year within 0.5 of a Supporting Professional Activity (SPA), although there are a number who do half of this.

The recruitment and retention of appraisers in Secondary Care can be challenging hence NHS Fife has the small bank of retired appraisers and are working on developing a strategy to attract eligible doctors to undertake appraiser training and encourage the recruitment of trained appraisers within Secondary Care.

NES offer the new appraiser training course with 2 courses available most months; however with the pressures on services, it remains difficult to recruit. The course is 2 half days delivered virtually in combination with e-learning modules. NHS Fife continues to advertise the training in the hope of attracting new appraisers.

Revalidation

There were 123 doctors in NHS Fife due for revalidation during 2023/2024. Of these, 112 received a positive recommendation and 12 were deferred, one of which later received a

positive recommendation during the same appraisal period. Reasons for deferral usually relate to doctors needing additional time to collect required information such as patient and colleague feedback. As the numbers are low this is monitored directly by the RO and their office. While some doctors do need additional support this is rare and most use the time given to actively under to work needed. There have been no requirements for non-engagement referrals to the GMC, by the RO in NHS Fife.

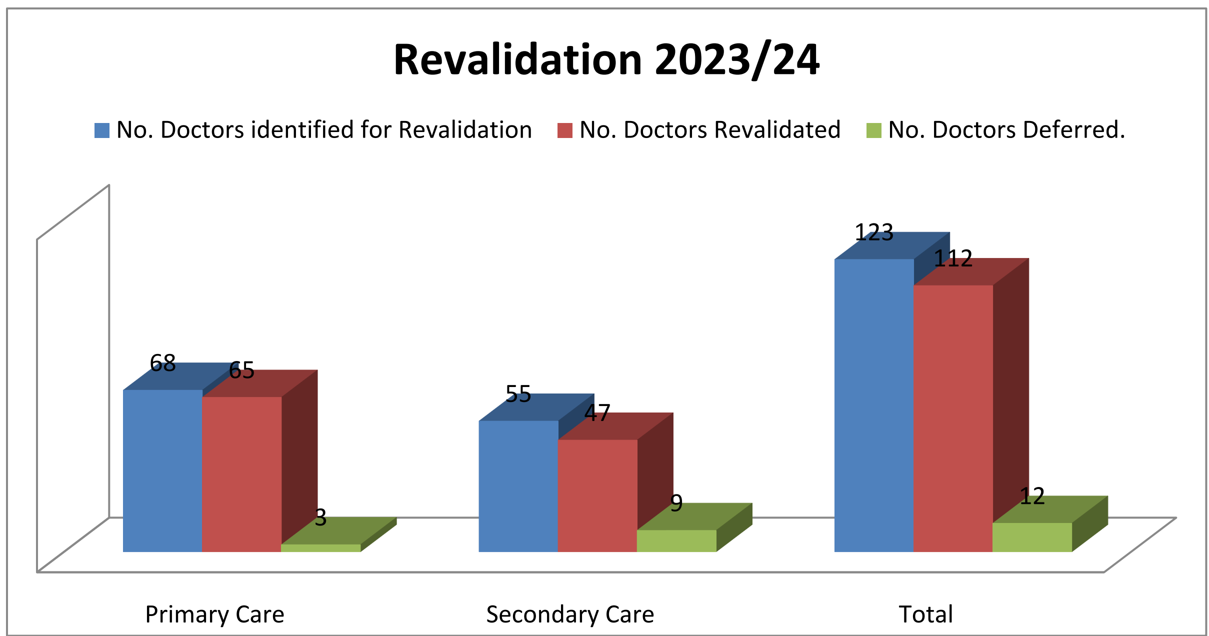

Chart 1: Revalidation 2023/2024

Appraisal within NHS Fife for Period 1 April 2023– 31 March 2024

As at 31 March 2024 there were 758 doctors with a prescribed connection to NHS Fife. This includes Primary Care (GP's), Secondary Care (Consultants, SAS Doctors, Clinical Fellows Honorary Consultants and Gateway Doctors), and University staff without an honorary contract.

The figures in Chart 2 show that the majority of those eligible managed to have an appraisal during 2023/2024. A proportion were not eligible because they were either new to their role and not yet due an appraisal during the period or were issued a Form 5A, giving them exemption for the period. Gateway Doctors are a new group of doctors within NHS Fife who although they have a connection to NHS Fife as their designated body for revalidation, have their appraisals managed and conducted by NHS Professionals on behalf of the Board and so were also not eligible for appraisal in NHS Fife.

Table 1 shows appraisal numbers for those eligible. Chart 3 shows the reasons for a Form 5A having been issued.

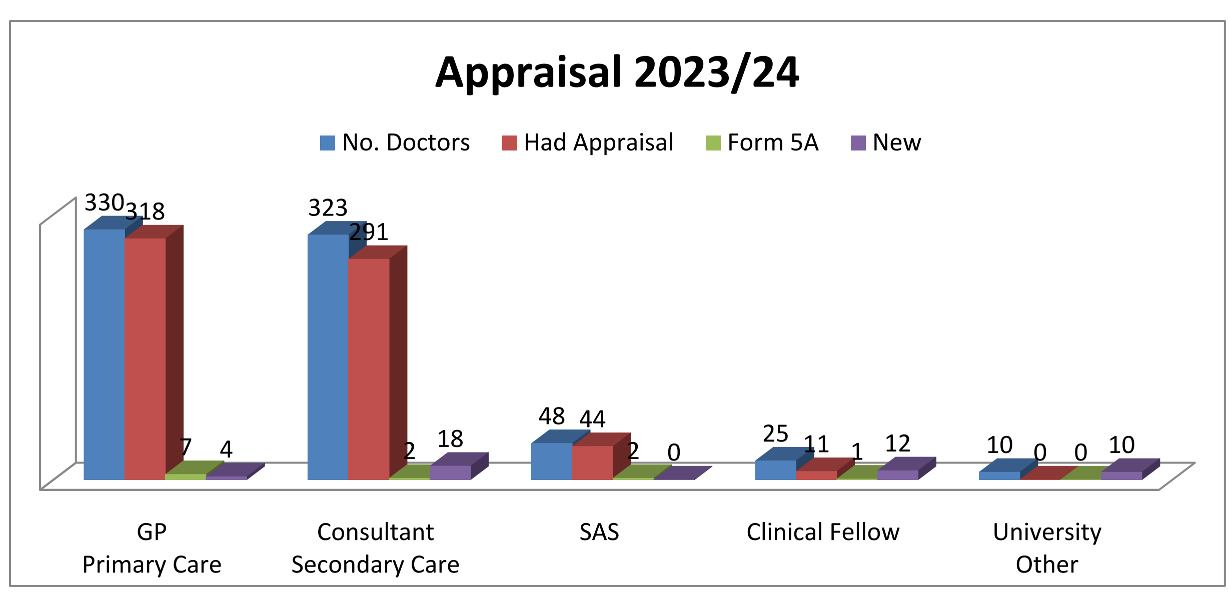

Chart 2: Appraisal 2022/2023

		No. Doctors	No. Not eligible (exempt or new)	**No. Eligible**	No. Had appraisal	**% had appraisal**
Primary Care	GP	330	22	**318**	313	**98.42%**
Secondary Care	Consultant	323	20	**303**	291	**96.03%**
	SAS	48	2	**44**	38	**86.36%**
	Clinical Fellow	25	13	**12**	11	**91.66%**
Other	University	10	10	**0**	0	**n/a**

Table 1: Appraisal Numbers - Those Eligible 2023/2024

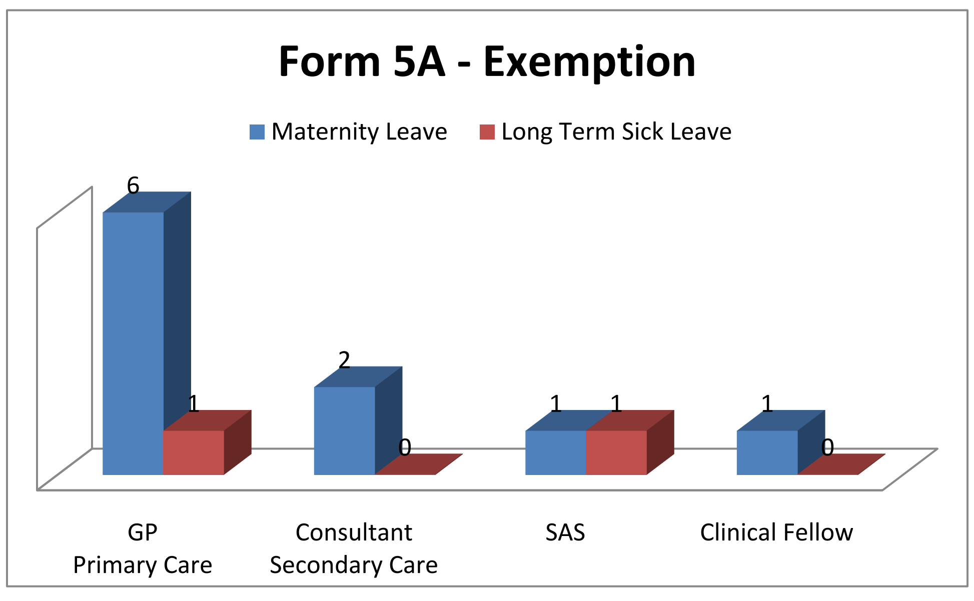

Chart 3: Form 5A's Issued 2023/2024

Summary

The key issues for 2023/2024

1. NHS Fife continues to respond well to the challenges of Medical Appraisal and Revalidation.
2. The GP Appraisal scheme in Fife continues to run well with little or no problems identified and therefore no further action is required at this time.
3. The Appraisal process in Secondary Care continues to run well with few problems identified other than recruitment and retention of Appraisers.

The key actions for 2024/2025

1. Continue to maintain an up-to-date record of all Consultants, Career Grade Doctors and General Practitioners with whom NHS Fife has a "prescribed connection".
2. Continue to develop and implement a strategy to encourage the recruitment of trained appraisers within secondary care in NHS Fife. Create a supportive 'myth busting' approach towards appraisal and revalidation in Fife.
3. Continue to support doctors with the appraisal/revalidation process.
4. Establish governance through new Medical and Dental Professional Standards Oversight Group overseeing the appraisal and revalidation processes and ensuring any issues/challenges that arise are resolved.
5. Comply with the Medical Appraisal and Revalidation Strategic Framework.

Alison Gracey
Medical Appraisal and Revalidation Coordinator
NHS Fife
20 September 2024

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Medicine Safety Review and Improvement Report 2023/24**
Responsible Executive:	**Fiona Forrest, Acting Director of Pharmacy and Medicines**
Report Author:	**Victoria Robb, Lead Pharmacist- Medicines Safety**

Executive Summary:

- Improving the quality and safety of care is a key priority of NHS Fife's Population Health and Wellbeing Strategy.
- The safe use of medicines, our most common healthcare intervention, is of critical importance to the safety and quality of patient care. Studies have shown that medicines contribute to between 5 and 30 per cent of hospital admissions and readmissions.
- This paper outlines the medicines safety approach in Fife through an annual report
- Delivery of a Medicines Safety programme is a corporate objective to ensure continuous improvements in patient safety and minimise risk of harm from medicines.
- A number of key enablers underpin the medicines safety approach such as robust medicines governance policies and procedures, audit and assurance and learning from medication incidents.

Medication Incidents

From April 2023- March 2024:

- 1580 medication incidents were reported compared to 1466 the previous year
- 72% of incidents were classed as "no harm" and 1.7% were classed as "major"
- The top 3 types of incidents were related to: administration, prescribing and supply
- Oxycodone (a high risk pain medicine) is the most reported medicine involved in incidents
- Actions taken include – developing an attractive stock dashboard and attractive stock organisational action plan and producing educational resources to support staff

High Risk Medicines Safety Programme

- The report outlines the aims of the programme to: embed an organisational learning culture from medication incidents and undertake a programme of proactive and preventative actions, to minimise the risk of harm across five specific high risk medicines.

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

2 Report summary

2.1 Situation

The safe use of medicines, our most common healthcare intervention, is of critical importance to the safety and quality of patient care. Studies have shown that medicines contribute to between 5 and 30 per cent of hospital admissions and readmissions.

Medicines safety is an NHS Fife corporate objective, which is delivered through a multi-disciplinary approach, including delivery of the High Risk Medicines Safety Programme to ensure continuous improvements in patient safety and minimise risk of harm from medicines.

The attached paper (Medicines Safety in NHS Fife Annual Report, provides a comprehensive update on current analysis and outlines the programme and wider actions being delivered.

2.2 Background

There were an estimated 2.9m administrations of medicines in the hospital setting last year, and 6.9m medicines prescribed in primary care, in Fife. There are over 125,000 people in Fife with at least one item prescribed in the last year. More widely, medicines related issues are one of the top causes of hospital admission in Scotland.

NHS Fife has a well embedded medicines governance structure to respond to and identify learning and actions from medication incidents. There is a multidisciplinary approach to medicines safety and also substantial local expertise across professional groups in both reactive and proactive improvement approaches.

2.3 Assessment

The attached "Medicines Safety in NHS Fife annual report" in appendix 1, provides analysis of medication incidents, actions undertaken to mitigate the risk of harm and the workplan for the NHS Fife High Risk Medicines Safety programme.

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 High Risk Medicines Safety programme contains five key areas of focus for the coming year. This programme and wider medicines safety improvement, will be supported and enhanced by delivery of improved digital systems, including HEPMA (Hospital Electronic Prescribing and Medicines Administration) over the coming months and years. The five areas are: High Risk Pain Medicines (HRPM), anticoagulants; lithium; insulin and sodium valproate. The report also details a range of actions which are being taken or will be taken over the coming months, to enhance quality and safety of care. This includes actions developed in response to ongoing review of incidents and associated learning, alongside the system priorities noted above.

2.3.2 Workforce

Responsibility for safe and high-quality use of medicines sits with healthcare professionals across all care settings, and therefore the actions and programme of work will impact upon all of them, and require their support and engagement. In particular, medical staff are the largest prescribers of medicines in Fife, and nursing staff administer most medicines. Pharmacists are recognised as medicines experts who take leadership of medicines governance in all care settings and who optimise therapeutic outcomes for individual patients. Medicines governance structures in NHS Fife are all multidisciplinary, with excellent engagement from medical, nursing and pharmacy staff.

The medicines safety approach in NHS Fife will embed an organisational learning culture across its workforce, to ensure continuous improvement in medicines safety.

To support the workforce with compliance against policies and procedures a number of presentations and supporting documents have been developed and are available on BLINK. New medicine safety minute bulletins are uploaded onto BLINK every week to support staff with learning from incidents.

2.3.3 Financial

There are no additional significant budgetary implications. Some limited directorate spending may be required on communications.

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 will follow in terms of reviewing and grading the event to ensure any lessons are learnt and improvements are made for the future. Major

medication incidents are monitored by the Medicines Safety and Policy group and reviewed by the Executive SAER panel, aligned to other incidents graded as "major". There is a risk that due to the Reform, Transform and Perform programme, delivery of the High Risk Medicines Safety programme may be impacted.

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

Use of medicines is more prevalent in deprived areas, and therefore these groups may be more likely to be affected by medicines safety issues. Should an EQIA be required as this programme evolves, this will be completed.

2.3.6 Climate Emergency & Sustainability Impact

This piece of work has no significant impact although reduction in error will have a causal link in reduction of waste. All work which reduces use of medicines will have a small environmental impact.

2.3.7 Communication, involvement, engagement and consultation

A multidisciplinary approach to medicines safety is embedded 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.

- Pharmacy Senior Leadership Team (PSLT) 14/08/2024
- Medicines Safety and Policy Group (MSPG) 04/09/2024
- Fife Area Pharmaceutical Committee (APC) 18/09/2024
- Executive Directors Group (EDG) 17/10/2024
- Clinical Governance Oversight Group 22/10/24
- Area Drugs and Therapeutics Committee 23/10/24

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a "**moderate"** Level of Assurance.
- **Discussion** – For examining and considering the implications of the matter.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Medicines Safety in NHS Fife Annual Report October 2024

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Pharmacy and Medicines Directorate

October 2024

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Published October 2024

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Introduction from the Director of Pharmacy and Medicines

The safe use of medicines, our most common healthcare intervention, is of critical importance to the safety and quality of patient care. Studies have shown that medicines contribute to between 5 and 30 per cent of hospital admissions and readmissions. Almost half are preventable, and it is estimated that admissions relating to adverse drug reactions, cost the NHS up to £466m annually. Every year in Fife, an estimated 2.9m medicines are administered in the acute hospital setting, and 6.9m prescribed in primary care.

As Acting Director of Pharmacy and Medicines, my role is to work in partnership with pharmacy, nursing, medical and AHP colleagues, to lead and oversee the safe use of medicines across Fife. This work is led through the High Risk Medicines Safety Programme, a corporate objective for NHS Fife, to ensure continuous improvements in patient safety and minimise risk of harm from medicines.

The High Risk Medicines Safety programme is underpinned by our medicines governance policies and processes, as well as a medicines audit and assurance programme. A key aim of the programme is also to develop a learning culture from medication incidents and identify actions which can be implemented across the organisation, to reduce the risk of further harm.

This report outlines the current position with regards to medicines safety in Fife, contextualises this both locally and nationally, and goes on to detail the programme of work to be undertaken over the coming year which will assure the Board that our patients are as safe as possible, and that are our teams adopting a culture of continuous improvement.

Fiona Forrest
Acting Director of Pharmacy and Medicines

Medicines Safety in NHS Fife

1. Context

1.1. Patient Stories

Patient safety is the cornerstone of high-quality healthcare, ensuring that patients receive care without suffering avoidable harm. Despite best efforts, however, medication incidents do occur, highlighting areas where improvements can be made. Each patient safety story offers valuable insights into the complexities of healthcare delivery and the importance of vigilance, communication, and robust systems and processes in preventing errors.

These are stories of patients who experienced medication errors during their care. Through this experience, we identified the gaps in current practice and explored strategies to enhance patient safety.

Patient Safety Story 1

An inpatient was prescribed regular diazepam for the management of agitation/distress. The treatment plan was to gradually reduce the dose due to adverse effects of the medication. The nursing team were required to half the tablets to be able to administer the correct dose for the patient, as diazepam liquid was out of stock long term.

Unfortunately, this process led to multiple medication errors and through reporting the incident on DATIX the multidisciplinary team met to identify the root causes of errors and actions to improve patient safety. A number of actions were implemented through multi-disciplinary collaboration across pharmacy, nursing and medical teams, which resulted in safe and timely administration of the medicine to the patient. The team reflected on the benefits of an open and honest culture in reporting incidents and the resulting improvements in patient care.

Patient Safety Story 2

Patient with complex health conditions was admitted to Victoria hospital due to a fall.

The patient was transferred to a community hospital for ongoing rehabilitation. 4 days after transfer, the patient became acutely unwell and was transferred back to Victoria hospital. At this point,it was identified that a dose of insulin had been missed the previous day. The patient required emergency medical treatment to stabilise them and required to stay as an inpatient in the acute setting for 48 hours before returning to continue rehabilitation at the community hospital.

A number of actions were implemented to share learning from this incident including Medicines Safety Bulletins on Missed doses and Safe Transfer of Patients.

A Local Adverse Event Review has been commissioned and a learn summary and action plan will be produced.

By examining these cases, we aim to shed light on the challenges and opportunities in patient safety, reinforcing the importance of continuous improvement and the adoption of best practice across all levels of healthcare. These stories serve as a powerful reminder of our collective responsibility to minimise risk of harm from medicines for those in our care.

Medicines Governance

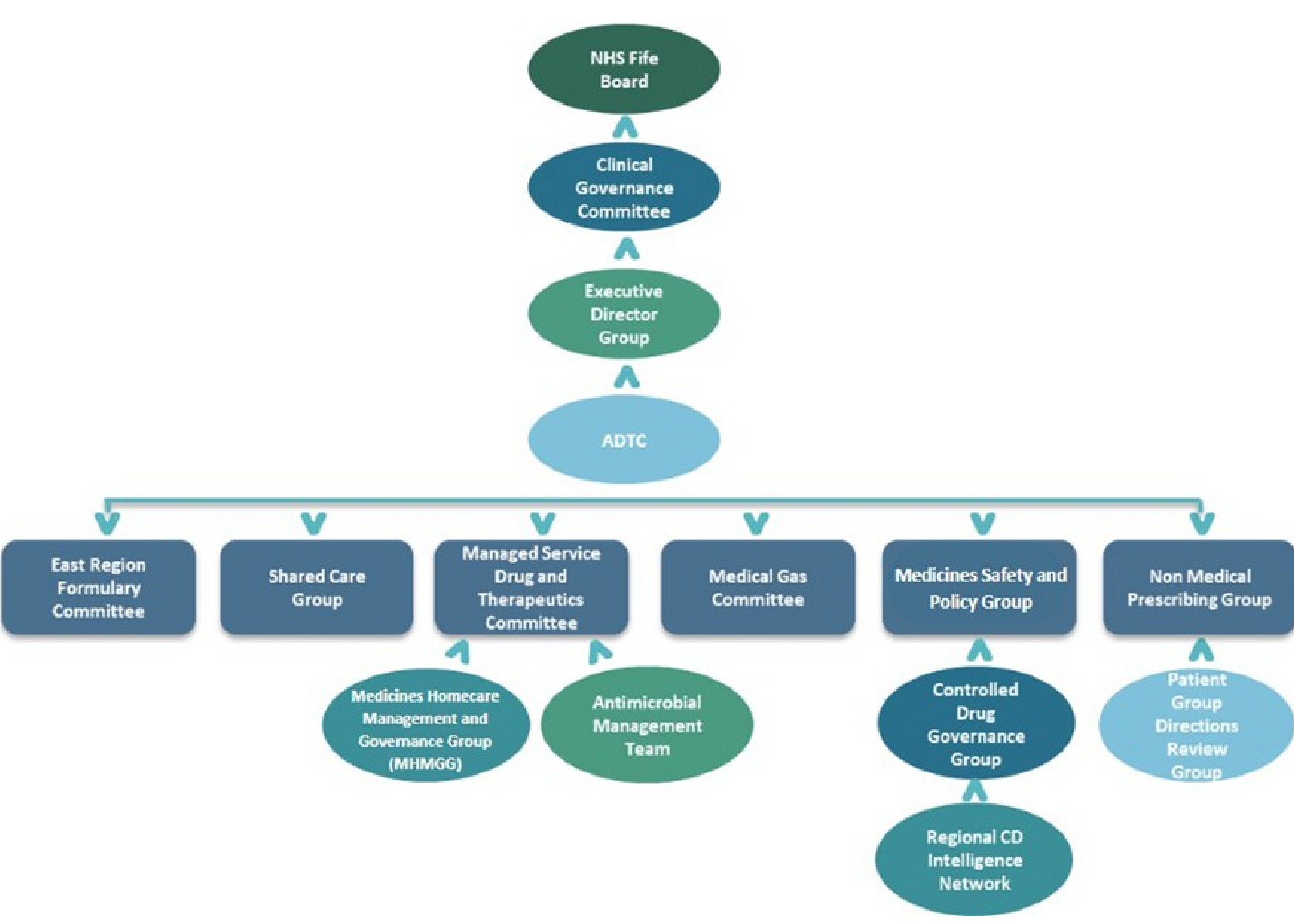
2. Roles and Structures

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 and are responsible for all aspects of controlled drug management. A Controlled Drug Governance group was established to strengthen scrutiny and assurance, which reports to the Medicines Safety and Policy group (MSPG) and Area Drug and Therapeutics Committee, as the overarching group for medicines governance in NHS Fife. Certain classifications of controlled drugs by law, require increased level of security and recording to prevent them from being misused, obtained illegally, or causing harm. 25% of all medication incidents across NHS Fife in 23/24 involved controlled drugs, the detailed analysis of which is included within the CDAO annual report.

NHS Fife Adverse Event policy (GP19) outlines how to report an adverse event and the process that will follow in terms of reviewing and grading the event to ensure any lessons are learnt and improvements are made for the future. All categories of controlled drug incidents are monitored in more detail through the Controlled Drugs Governance group, including any controlled drug incidents from community pharmacy or General Practice. Any incident involving missing or unaccounted controlled drugs, is graded as “Major” and undergoes Significant Adverse Event Review.

Fife Area Drug and Therapeutics Committee's (ADTC) remit is to provide assurance to NHS Fife board on all aspects of safe, quality and, cost-effective prescribing, medicines utilisation and governance, aligned with NHS Fife strategies and relevant legislation. Diagram 1 below outlines NHS Fife’s medicine governance structure, with dual reporting, where appropriate, to the Acute Services Division Clinical Governance Committee and HSCP Quality Matters Assurance group and the Clinical Governance Oversight Group.

Diagram 1:
NHS Fife Medicine Governance Structure



Medication Incidents in Fife

3. Medication incidents in Fife – April 2022 to March 2024

The reporting of medication incidents is essential to develop a culture across the organisation, of openness, honesty and learning, and is given due diligence. The number of incidents reported as a single metric, should not be of concern; evidence suggests that healthcare services with more frequent reporting and a good learning culture, have less frequent occurrences of actual harm. Each medication incident reported, is an opportunity to learn and improve and therefore what is essential, is how learning is put into practice, shared across the system and used to drive improvement.

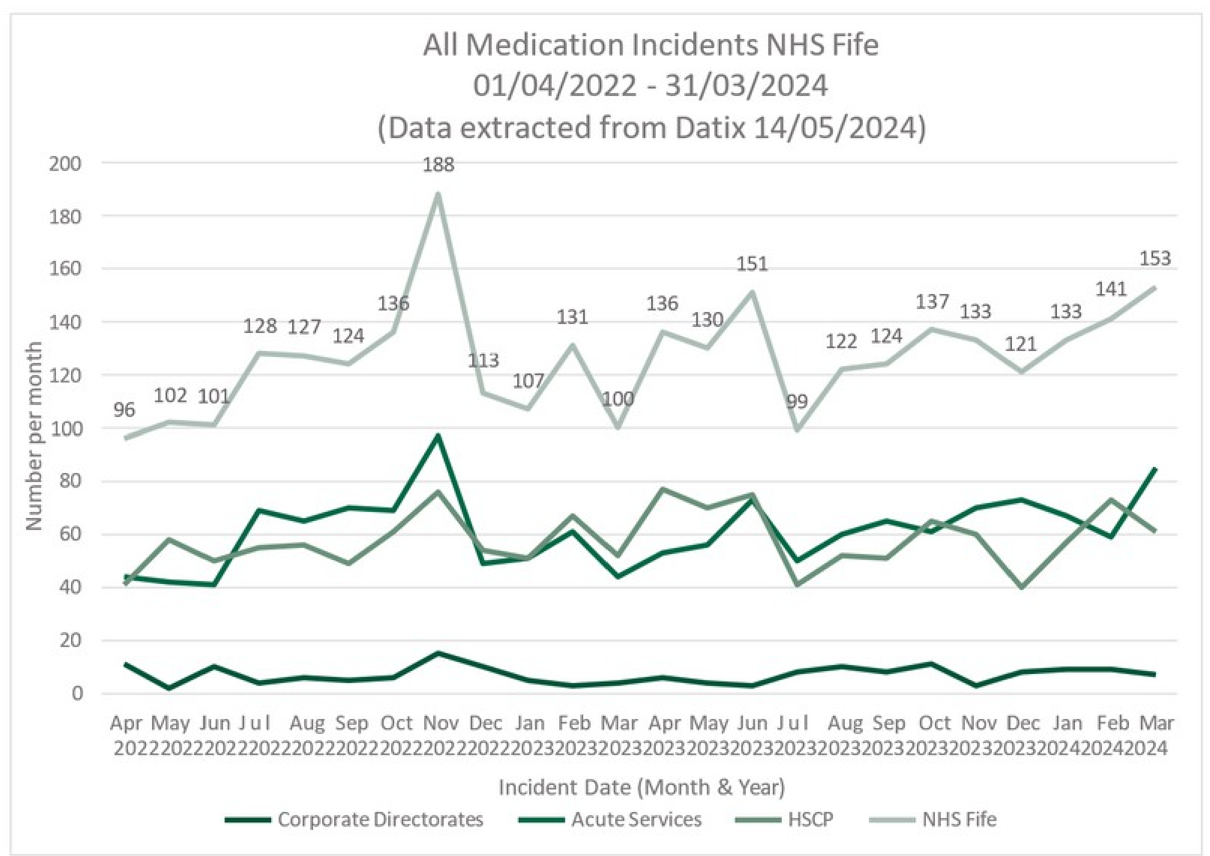
In NHS Fife, there is an established process of reviewing incidents, to ensure a rapid learning approach is followed. This is achieved by a weekly safety huddle, with multi-disciplinary membership across Acute Services and HSCP, which scrutinises the previous week's medication incidents. The themes and learning from these incidents are shared through the circulation and publication on Stafflink, of a weekly Medicines Safety Minute (MSM) briefing to all professional groups. The MSM is used by wards, departments and teams as part of weekly safety huddles. As well as addressing any immediate learning, it embeds a culture of regular and routine focus on medicines safety across clinical teams.

3.1. Medication Incidents Reported

A total of 1580 medicine incidents were reported on Datix during April 2023-March 2024, compared to 1446 during April 2022-March 2023. Graph 1 below shows the spread of reported incidents from April 2022 to March 2024, as a total for the whole of NHS Fife, and broken down into the Acute Service Division (ASD), Fife Health and Social Care Partnership (HSCP) and Corporate Directorates respectively. The peak seen in November 2022 was due to the medical gas audit, which was conducted in this month, and reported via DATIX allow each ward/ department to receive the detailed report and any actions required. The remainder of the graph is typical from previous years with peaks and troughs in reporting.

Graph 1:

Number of medication Incidents reported via Datix from April 2022 to March 2024



3.2. Severity of Medication Incidents

Reporters of incidents grade the immediate impact of the incident on the affected person. (Please note: In some cases, the final risk grading may change following review). Graph 2 details the number of medication incidents according to harm, comparing the last 3 years.

- 72 % of medication incidents in 2023/2024 resulted in "no harm", compared with 71% in 2022/2023 and 72 % in 2021/2022.
- 27 "major" medication incidents were reported in 2023/2024 compared to 16 in 2022/2023 and 18 in 2021/2022, the majority of which related to "missing or unaccounted" controlled drugs.

NHS Fife records incidents of missing controlled drugs as "major" to ensure the incident is escalated immediately and appropriate action taken, with early oversight of senior leaders. The incidents are downgraded if the medication is subsequently found; for example, a calculation error was discovered in the controlled drug register resulting in the discrepancy being resolved. There is currently no national comparison between Boards regarding medication incidents due to the different ways in which we categorise and report.

Graph 2:

Medication incidents by Severity of Outcome: 2021-22,2022-23 and 2023-2024

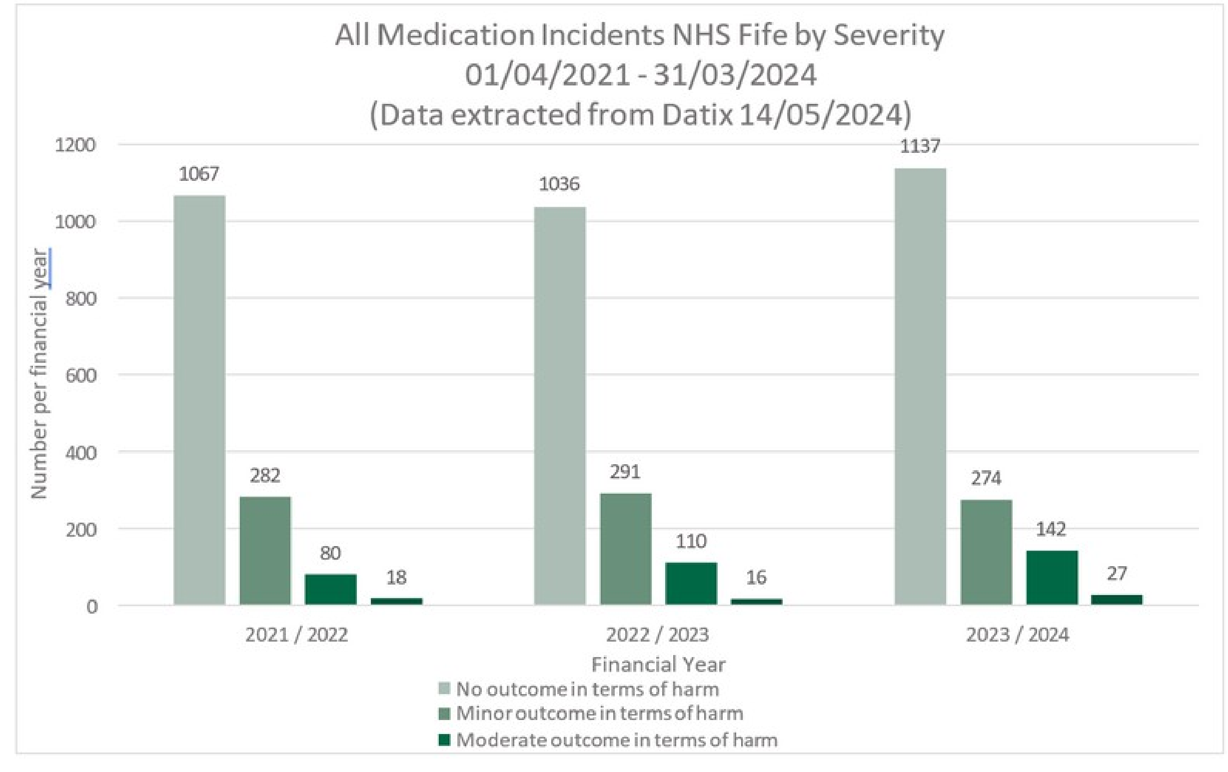


Table 2 below describes the 27 major incidents reported in 2023/2024 and learning actions.

Table 2:
Major incidents reported in Datix 2023-2024

Type of Major incident (number of incidents)	Learning Actions
Missing medication (13)- controlled drugs or "attractive" medicines	An attractive stock dashboard has been embedded into practice, where there are 100% monthly checks for all wards/ departments to identify any areas of concern. Key themes and learning from all missing medication incidents has resulted in an organisation action plan overseen by the Medicines Safety and Policy Group and CD Governance group.
Administration (Missed dose, Wrong dose / drug / infusion) (5)	Medicines Safety Minutes (MSM) disseminated on various themes developed from these incidents
Discrepancy in controlled drug register (2)	CD Audits continue on a 6 monthly basis and action plans produced at ward level.
Missing/forged - prescription/CD stationery (1)	Process for checking HBP pads has been reviewed and updated
Monitoring / Follow up (1)	MSM disseminated - Monitoring of medicines administered via an infusion device.
Prescribing (3)	MSM's disseminated including safer Prescribing of VTE prophylaxis, Guidance on Prescribing of Once Weekly or Alternate Day doses and Legal prescription requirements.
Security (1)	SAER commissioned – learning / action plan will be developed.
Storage / transportation (1)	2nd cycle of transport audit has been completed and action plan developed to support change where learning needs have been identified.

ACTION:

An attractive stock dashboard (ASD) has been developed by NHS Fife, which details all medication supplied to wards and departments that may be desirable and therefore at increased risk of diversion. The clinical pharmacist for each ward or department review this with senior nursing and medical staff every month, to identify any areas of concern.

In NHS Fife, a Key Performance Indicator of 100% has been set, with this being achieved since January 2024 onwards.

ACTION:

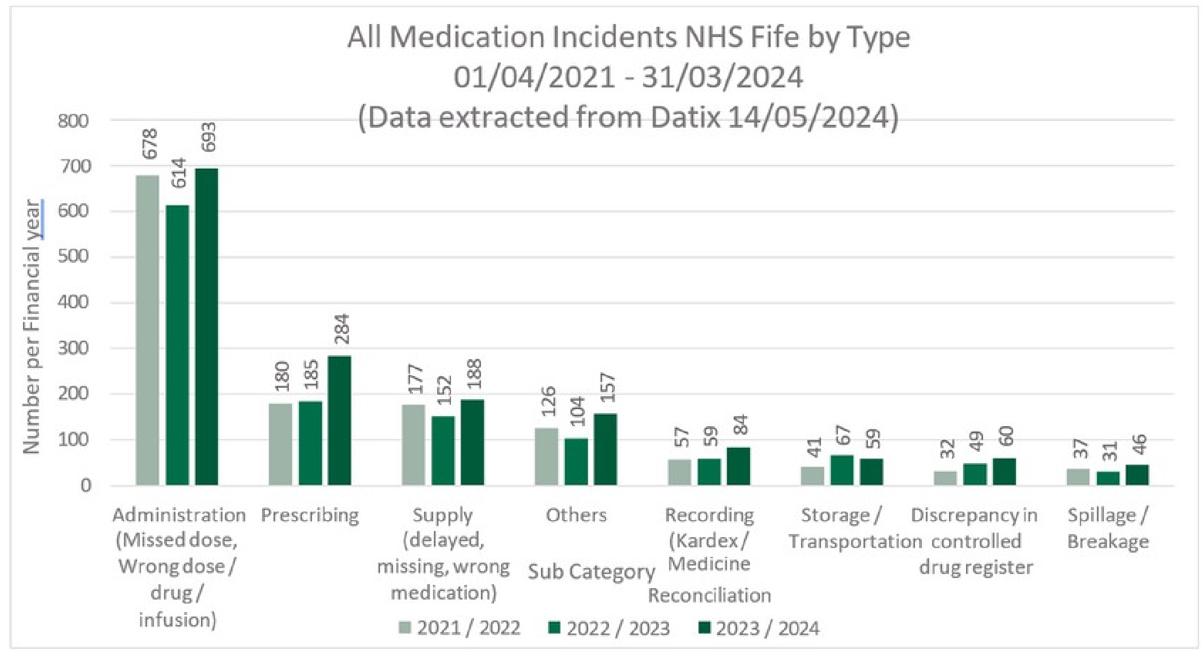
An Attractive Stock Organisation Action Plan has been developed collating key themes and learning from recent SAERs and LAERS to support delivery of change or learning, with oversight from the CD Governance Group.

3.3. Categories of Medication Incidents

Graph 3 details the type of medication incidents reported, with administration errors continuing to be the most common, followed by prescribing. The top three types of medication incidents ie administration, prescribing and supplyhave remained the same as lastyear and the year before.

Graph 3:

Type of Medication Incidents: 2021-2022, 2022-23 and 2023-2024

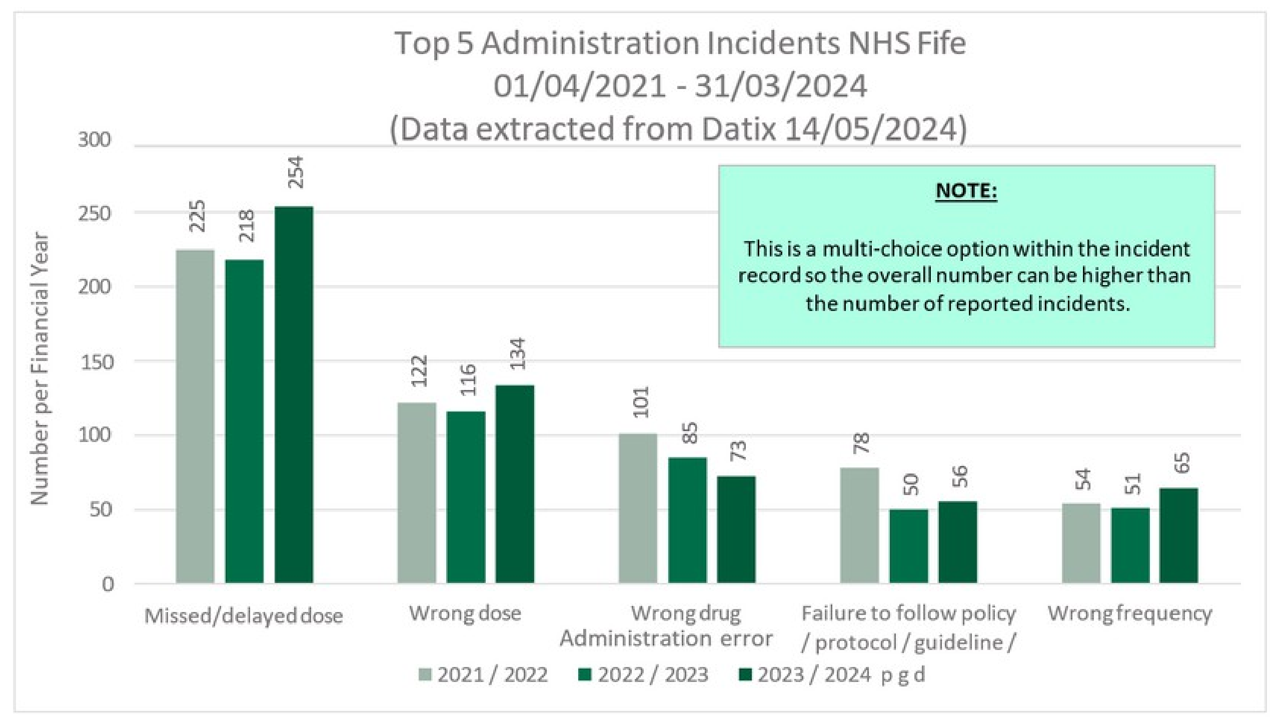


Graph 4 breaksdown the type of administration error with missed /delayed dose accounting for 254 of administration errors.

The top three types of administration errors have continued to be the same over the last few years i.e. missed/delayed dose, wrong dose, wrong drug. To support staff with learning from administration incidents a range of Medicines Safety Minutes have been written covering medicines administration. For example, Safety Checks before administering medicines and Safer administration of specific types of medicines e.g. transdermal (skin) patches.

Graph 4:

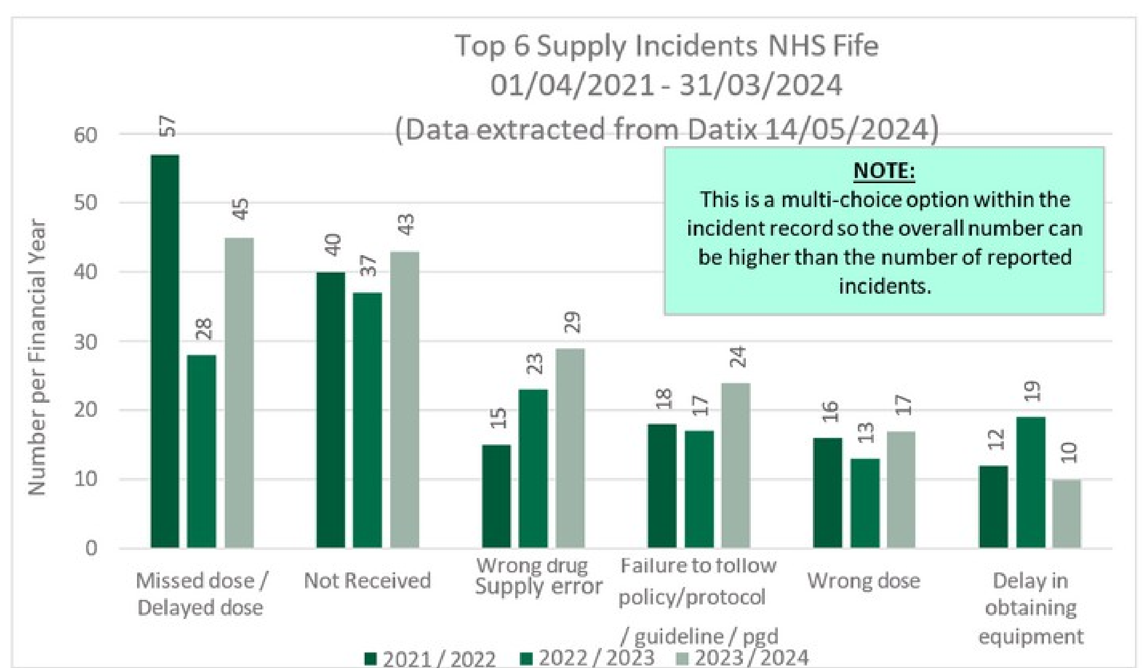
Top 5 Administration Incidents: 2021-2022, 2022-2023 and 2023--2024



Graph 5 breaks down the types of supply incidents with missed delayed dose being the most common and not received being the next most common, which is the reverse of the previous year.

Graph 5:

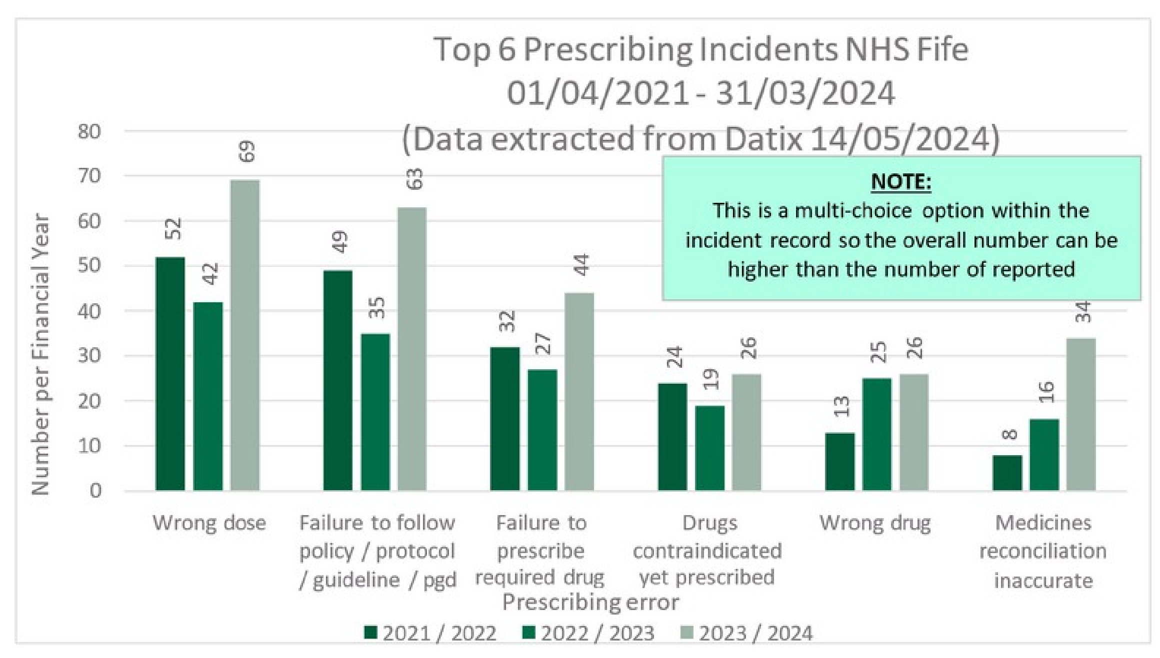
Supply Incidents: 2021-2022, 2022-2023 and 2023--2024



Graph 6 breaks down the type of prescribing errors. Wrong dose is the most common at 69. Failure to follow guideline/policy/procedure/PGD was the next most common at 63 then failure to prescribe at 44. The top 3 remains the same as the previous two years. Prescribing errors are reviewed by the medical education team and learning disseminated. Medication safety minutes also contain learning from prescribing errors and a new East Region Formulary Website has been launched to support clinicians.

Graph 6:

Prescribing Incidents: 2021-22/2022-23



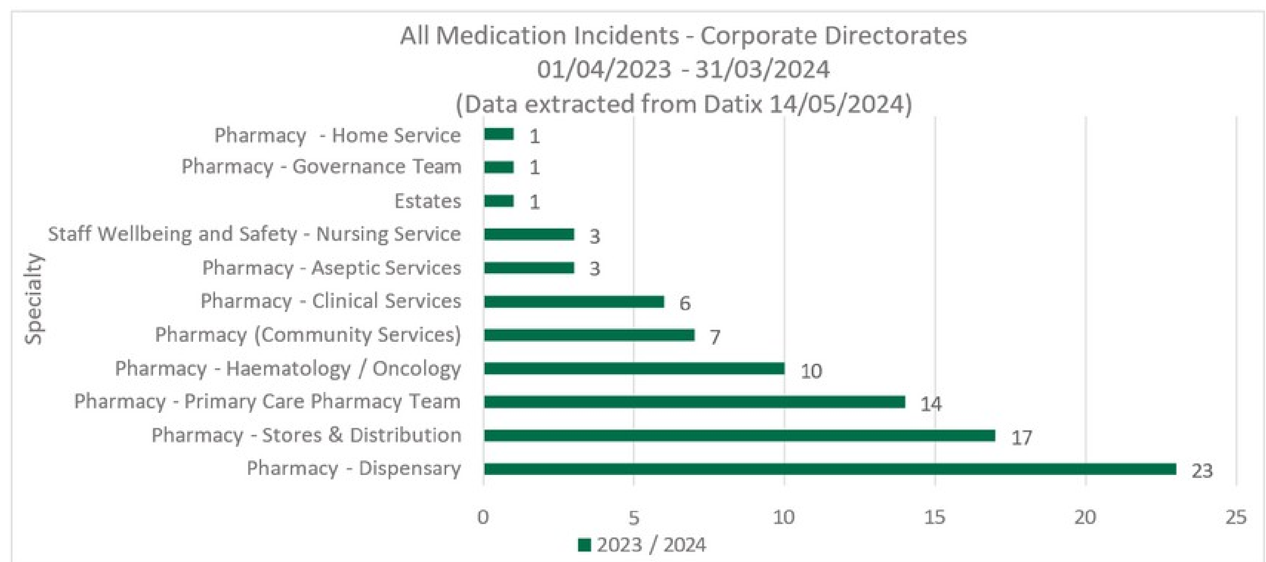
3.4. Medications Involved in Incidents

3.4.1 Corporate Medication Incidents

Graph 8 demonstrates the specialty involved in a total of 86 medication incidents reported under Corporate Directorate. The graph demonstrates that all services report medication incidents, to ensure improvement and learning is shared across all specialties as well as support services.

Graph 8:

Corporate medication Incidents 2023-2024



Following the investigation of incidents, several pharmacy processes have been reviewed and updated. These updates include improvements to the ordering and supply processes, as well as revisions to the Standard Operating Procedure (SOP) for the management of returned medicines.

NHS Fife High Risk Medicines Safety Programme

What has been described so far in this paper relates to the overarching approach to medicines safety and governance, as well as the organisational learning strategy. This provides assurance that the overall governance and learning system is in place, functioning appropriately and reacting to incidents a culture which is open to improvement.

There are number of areas in which a proactive preventative programme is required which represent foundations of medicines safety continuous improvement. The Board has identified medicines safety as a corporate objective, which is a commitment to ensuring a continuous focus on improving patient outcomes and reducing risk of harm from medicines. There are five high risk medicines areas which have been identified from local medication incidents and National Patient Safety Alerts. High risk medicines are defined by HIS "as medicines that have a high risk of causing injury or harm if they are misused or used in error":

a. Anticoagulants
b. Insulin
c. Lithium
d. Sodium valproate
e. High Risk Pain Medicines(HRPM)

The following sections describe this programme which will be overseen by the multi-disciplinary Medicines Safety and Policy group, reporting to Area Drug and Therapeutics Committee, with clear links through Pharmacy Senior Leadership Team and the HSCP and Acute Services governance groups.

In addition, there are a number of key systems and processes which are enablers to delivery:

1. **Revamp of the Safe and Secure Use of Medicines Policies and Procedures (SSUMPP),** incorporating an improved content layout and a medicines section on BLINK, supporting usability and adherence across the multi- disciplinary team.

2. **Ease of access to Policy and Guidelines** – focused around the revised section on BLINK, and including formulary information and other medicines policies.

3. **Revised Medicines Audit and Assurance programme** which is detailed in table 3 in the report.

4. **Controlled Drugs management**, through the Controlled Drug Governance group which oversees the annual controlled drugs report.

5. **Medicines safety huddle**, as noted above, an ongoing weekly review of incidents by the MDT with a focus on administration, prescribing and supply of medicines. This approach produces a weekly Medicines Safety Minute available to all healthcare professionals across Fife.

6. **A focus on organisational learning** which underpins the approach across all staff groups and drives the culture of improvement across NHS Fife.

7. **Digital Medicines Programme** - implementation of a new electronic discharge document system and HEPMA(Hospital Electronic Prescribing and Medicines Administration) during 2024- 2026, will improve the quality and safety of prescribing.

4.1. Focus on Anticoagulant Prescribing and Administration

Anticoagulant medicines are very effective at preventing and treating clots, but they can also be harmful if they are prescribed or administered incorrectly. Reducing errors associated with anticoagulants is important, because oral warfarin, Directly Acting Anticoagulants (DOACs), injected heparin and low molecular weight heparin errors have been recorded on the Datix system and caused patient harm.

An anticoagulant medicines safety group comprising of multi-disciplinary team members working across NHS Fife has been established. A terms of reference and a programme of improvement have been developed, with the aim of improving anticoagulant medicine prescribing, administration, monitoring and education and training.

There are thousands of NHS Fife patients prescribed DOAC medicines. To improve medicines safety with this cohort of patients in primary care, the anticoagulant medicines safety group are investigating the best way to identify, prioritise and monitor these patients in an efficient, structured and timely manner, whilst recognising the competing demands in primary care.
An audit of the prescribing and documentation of anticoagulant medicines was undertaken in four acute hospital wards. The results of which will be incorporated into the prescribing section of the work plan.

A DOAC counselling pack for pharmacy staff has been developed for use in acute and community hospital clinical areas and is currently being implemented. This will standardise the DOAC medicine counselling, improve medicines adherence, increase the patient's knowledge of these medicines and help to reduce DOAC adverse events.

The anticoagulant medicine education and training for healthcare professionals is being reviewed. After initial discussions with Medical Education, the anticoagulant medicine learning will be incorporated into the post graduate FY1 andFY2 training. The education and training for the wider health and social care staff is also being explored.

In the longer term, the introduction of the HEPMA system will have a positive impact on safety in this area through implementation of a safety alert. For the coming year, a multi-disciplinary and whole system approach is critical to ensuring safe patient care.

4.2. Focus on Lithium Prescribing and Management

Lithium is an effective medicine, particularly in the maintenance treatment for bipolar disorder, recurrent depression, and with growing evidence of suicide-protective effects. Research informs us that in Scotland the use of lithium has declined in recent years, despite lithium being recognised as the gold standard treatment for bipolar disorder.

A SLWG multidisciplinary team, with representation from primary and secondary care, Mental Health and the Medicines Management Team, was established. Their role was to determine the quickest and most effective way to audit and review all patients currently prescribed lithium (currently 339 patients in NHS Fife), to ensure they meet the requirements outlined in the CMO's National Guidance for Lithium Monitoring.

The original SLWG group has now evolved into the Lithium Medicines Safety Group and a terms of reference and a programme of improvement have been developed with the aim of improving lithium prescribing, administration, monitoring and education and training.

This is a complex picture including management by both primary and secondary care clinicians. In many cases, patients may have shared care agreements (which clarifies responsibility for aspects of care between general practice and specialists) in place, to ensure highest quality support and co-ordination of care between clinicians.

Lithium has a narrow therapeutic index and requires tight control of prescribing and adherence to prevent toxicity, whilst also ensuring that the dose is therapeutic. Even at the optimal dose, it can have side effects, and long-term use can be associated with thyroid disorders and cognitive impairment. As a teratogenic medicine, it can also have a particularly negative impact during pregnancy, and therefore requires special considerations for some patients.

Audit and improvement work for patients taking Lithium will be undertaken to improve compliance to monitoring requirement for this patient group as outlined in the CMO Guidance for Lithium Monitoring 2019. This will include:

- Update Shared Care Agreement for Lithium to reflect monitoring guidance for patients prescribed Lithium as per CMO 2019 guidance.

- Completion of a baseline audit on Lithium monitoring adherence as per CMO 2019 guidance for every patient prescribed Lithium across NHS Fife, which will be shared with individual GP practices for action.

- Support each GP Practice to embed a business-as-usual model for monitoring patients who are prescribed Lithium.

- Repeat audit of compliance to Lithium Monitoring guidance as outlined in CMO guidance on a yearly basis.

4.3. Focus on Insulin Prescribing and Administration

The Insulin Safety group has transitioned from the short-life working group and is now fully established comprising of multi-disciplinary team members working across different healthcare settings. The group meets regularly to discuss and review Datix incident themes and identify key learnings. One of the primary methods for disseminating these learnings is through Medicines Safety Minute bulletins. For example, Monitoring Blood Glucose in Hospital – point of care testing.

It also develops materials to support ongoing education. The group is preparing the following support materials which, once approved via formal governance routes , will support safer insulin management across NHS Fife -

- Diabetes 10 point training
- Guidance on self administration of insulin (acute)
- Guidance on insulin prescribing on admission
- Guidance on insulin prescribing on discharge
- Guidance on insulin in patient use and supply

The group regularly collaborates with and updates the Diabetes Managed Clinical Network on progress to ensure streamlined work.

4.4. To continue to develop and enhance our approach to prescribing of Sodium Valproate

In 2018, the Medicines and Healthcare products Regulatory Agency (MHRA) introduced a requirement that valproate medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme (Prevent) is in place. All women and girls (and their parent, caregiver, or responsible person, if necessary) must be fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy. If valproate is taken during pregnancy, up to 4 in 10 babies are at risk of developmental disorders, and approximately 1 in 10 are at risk of birth defects.

In 2019 a Short Life Working Group of relevant clinical experts was set up to respond to the MHRA guidance. This group produced an annual audit to review all women and girls of childbearing potential to ensure they met the audit standards. This audit has been completed in 2019, 2020, 2021 and 2022.

In 2022 a thorough review has been carried out into the audit process and as a result the audit has been amended to include a follow up process to ensure delivery of more detailed outcomes ensuring the safety of the childbearing population of NHS Fife.

In December 2023 in response to the Sodium Valproate National Patient Safety alert a Valproate Safety Steering group was formed to oversee the work of the newly formed Valproate Safety Operational Group.

The membership of the Operational group was drawn from all specialties involved in the prescribing to and management of Valproate patients. It included members of all professions related to these specialties from both Primary and Secondary care. This group was tasked with a number of actions including:

1. How to implement the new legislative requirements.
2. The creation of new pathways to clearly articulate the implementation detailing clear roles and responsibilities.
3. Communications of the pathways.
4. Creation of a database of valproate patients to make their identification easier and allow clear identification of workload for each specialty.
5. Identification of patients with lived experience of valproate to assist in the work.
6. A series of audits to ensure full implementation of new pathways is achieved.

The group has been well supported by all specialties and has achieved most of the goals that were set for it. With the assistance of the Clinical Effectiveness team, the group has created 5 brand new Valproate prescribing pathways to fully deliver the legislative requirements. These are awaiting final governance approval before communication to all stakeholders. The Clinical Effectiveness Team also helped create a new database of all patients in NHS Fife being prescribed.

All specialties will have access to their own patients through this database to ensure we satisfy all GDPR requirements.

The Valproate Safety Steering Group will be stood down and oversight of Valproate safety in NHS Fife will be passed to the Medicines Safety and Policy group.

The future work still to be developed is the Public Health based work around patients with lived experience and identifying any areas of inequality that need to be addressed. We currently await a decision from Healthcare Improvement Scotland (HIS) if they are going to carry out national work in terms of patients with lived experience. A decision on this is due in August 2024.

4.5. High Risk Pain Medicines

Over 38% of the adult population in Scotland live with chronic pain and pain medicines remain the most common intervention. These medicines include opioids like codeine and morphine, gabapentin and pregabalin which are used in the treatment of nerve pain, anti-inflammatories such as ibuprofen and naproxen and benzodiazepines like diazepam, sometimes used for muscle spasm. Not only do these medicines often come with side effects like drowsiness, constipation and nausea, longer-term use of some of them can also lead to physical dependence and create a greater risk of overdose.

NHS Fife are high prescribers of pain medicines in comparison to other Scottish health board areas and we have a higher involvement of prescribable pain medicines in nationally reported drug related deaths as well as consistently involved in local Datix reporting incidents.

The High Risk Pain Medicine (HRPM) Patient safety programme was established as a corporate objective with the aim of changing the culture in two key areas:

- How we prescribe pain medicines
- How we support patients managing pain

The programme was system wide and during Year 1 “Understanding the Problem” extensive consultation was undertaken with patients, carers and staff across NHS Fife and health and social care as well as auditing of systems and processes to identify potential areas for improvement. Through a corporate programme structure of a programme board and workstreams with members representing services and professions across NHS Fife and the HSCP. During Year 2 the workstreams progressed key deliverables aimed at creating the following benefits -

- More Empowered Patients
- Enabled Skilled Workforce
- Safer Prescribing of HRPM
- Improved Cost Effectiveness

The key deliverables progressed in Year 2 were as follows:

1. “Pain Talking” Resource Hub - A web based “one stop shop” for the public to help support pain management understanding and key pain medicine safety messages. The web based resource “Pain Talking” went live in at the end of May 2024. www.nhsfife.org/paintalking.
2. Public Campaign- social media campaign disseminating key pain medicine safety messages.
3. Pain Champion Network- established a network of >30 champions system wide to identify and deliver quality improvement opportunities within their services in relation to medicine safety and pain management.

4. **Training Response** - Suite of training resources developed and delivered across multi-professional groups.
5. **Evidence and Guidance update** - updated pain guidance with quick reference guides to make them more accessible complimented by short video campaign planned for Autumn 2024.
6. **Community Education Sessions** - Fife Pain Management Team developed a 1 hr community education session called "Sore? Know More!" that is available for people living with pain, carers and clinicians. It is delivered at venues across Fife on a rolling monthly basis to aid understanding of pain management and key pain medicine safety messages.
7. **Lived Experience Group** - group was established and members shared stories of their experience living with pain and finding alternatives to medicine.
8. **Incremental Tests of Change (ToC) in Acute & Primary Care settings** - a number of ToC were undertaken with a focus on improving safety and processes associated with pain medicine prescribing.

Primary Care examples include:

- Issuing smaller quantities of opioids and gabapentinoids at first prescription, this will reduce waste by reducing the quantity of unused medicines available in the community at risk of intended or unintended diversion.
- When initiating prescribing of an HRPM issuing a medicines safety card which incorporates key messages to help manage expectation around short term use, side effects and risk and storage suggestions.
- Use of a leaflet to support patient consultations as they move from acute to chronic pain and shift the focus away from medicines as the only solution.

Secondary Care examples include:

- Development and use of a standardised post operative patient medicines leaflet.
- Development and use of a standardised discharge template for IDL to ensure adequate information is given at the interface to support appropriate discontinuation of medicines or review and continuation.

Positive outcomes were achieved with all tests of change with good acceptability by patients and clinicians and most importantly reduced risk of harm to patients. Opportunities to scale the work up have to be explored as part of the new HRPM Safety group. Primary care clinicians have fed back positively on the improvement in interface communication. Medicine cards and Leaflets have been disseminated across GP Practices, ward settings and via Pain Champions.

All deliverables have been fully assessed and recommendations made as to whether they should be adopted across Fife. The programme has been welcomed by staff and patients and there are some early signs of positive changes in relation to HRPM prescribing, as defined by National Therapeutic indicators.

Due to current financial pressures and the Reform Transform Perform response, the programme has transitioned to a business-as-usual model earlier than anticipated with the formation of a new HRPM Safety Group taking on the mantle of continuing the work. The group have agreed Terms of Reference and are in the process of prioritising which of the deliverables progressed in year 2 can be scaled, continuing a focus across all settings.

Audit and Assurance

Medicines continue to be the most common therapeutic intervention in healthcare, and the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) is the main document that details the systems and processes in place to ensure the safe and secure prescribing, administration, supply, storage and destruction of medicines - including controlled drugs.

Following a number of serious medication incidents in late 2016 early 2017, a wholesale review of the Policy was undertaken, and an audit programme developed to provide assurance that the requirements of the policy were being implemented and met.
The Safe and Secure Use of Medicines Group (now Medicines Safety and Policy group) agreed to review the audit programme to create a sustainable Medicines Audit and Assurance Programme going forward.

In 2018, sixteen audits were agreed and prioritised by identifying the risk, reviewing the assurance against the three lines of defence model and agreeing the areas of the SSUMPP being audited.

All audit reports and action plans as a result are reviewed and monitored by The Medicines Safety and Policy group (MSPG) with assurance provided to Area Drug and Therapeutic Committee. Table 3 below details the audits completed in 2023. These conclude the 5 year cycle.
In October 2023 the Safe Use of Medicines Group approved the establishment of a Short Life Working Group to review and revise the Medicines Assurance Audit Programme to reflect the current risk environment and the current iteration of the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP). The Medicines Audit and Assurance programme (MAAP) SLWG met three times and produced a revised MAAP plan. This was taken to MSPG and it was agreed that the MAAP should be further reviewed to ensure it is fit for purpose. This review is currently underway.

Table 3:

Audit and Assurance Programme

Audit	*How often/Areas covered	*Status	Current update
NHS Scotland Systemic Anti-Cancer Therapy Services Review (Compliance against the CEL 30 SACT Governance Framework) Note - Replaces the Clinical Management Guidelines, for Systemic anti cancer Therapy (SACT) protocols	3 year audit cycle	Update on action plan to HIS via regional cancer network due April 2024	Actions from audit are monitored by HIS via the regional cancer networks.
Controlled drug audit	Annually- all wards/depts that hold schedule 2 or 3 controlled drugs that require safe storage	Plan in place for January – June 2024	Actions from audit are monitored by CDGG and MSPG with 6 monthly updates to ADTC
Provision of Discharge Medicines and Medicines to Take Home	Twice in 5 Years- Sample of wards/depts across ASD and HSCP	Completed SSUOMG in May 23 ADTC September 23	Actions from audit are monitored by MSPG with 6 monthly updates to ADTC
Controlled Drugs Observational Audit – Wards	Twice in 5 Years all wards/depts that hold schedule 2 or 3 controlled drugs that require safe storage	Completed	Actions from audit will be monitored by CDGG and MSPG with 6 monthly updates to ADTC

Controlled Drugs Observational Audit – Theatres	Twice in 5 Years- All theatres	Completed December 2023	Actions from audit will be monitored by CDGG and MSPG with 6 monthly updates to ADTC
Medicines Administration Observational Audit - Wards	Twice in 5 Years- all inpatient wards/depts	Completed	Actions from audit will be monitored by MSPG with 6 monthly updates to ADTC
Return and Destruction of Medicines	Twice in 5 Years- Sample of wards across HSCP and ASD and pharmacy stores	Received by ADTC April 23	Actions from audit will be monitored by MSPG with 6 monthly updates to ADTC
Transportation of medicine	Once in 5 years – Sample of wards across HSCP and ASD ,pharmacy stores , hospital dispensaries and portering services	1st and 2nd cycle of audit completed 2023/2024	Conducted by internal audit and actions monitored by Audit and Risk Committee, assurance given to MSPG and ADTC. 2nd cycle complete and action plan to be monitored by MSPG with 6 monthly updated to ADTC
Medicines Requiring Refrigeration – Hospital wards/ departments	Every 2 years ASD 2022 – was completed HSCP 2023 – **was postponed** All wards/departments that have a refrigerator	Target completion date for HSCP 01/11/2024	Actions from audit are monitored by MSPG with 6 monthly updates to ADTC

Medical Gases – Wards/ departments	Annually - all wards and departments that hold medical gases	2022 audit reviewed by medical gases committee June 2023. Next cycle commenced with target completion June 2024.	Actions from audit are monitored by Medical Gas Committee with 6 monthly updates to ADTC
Medical Gases – Stores	Annually - all medical gas stores	2022 audit reviewed by medical gases committee June 2023. Next cycle commenced with target completion June 2024.	Actions from audit are monitored by Medical Gas Committee with 6 monthly updates to ADTC
Security and storage of medicines	Once in 5-year cycle – all areas that store medicines	Completed. HSCP target completion November 2024.	Actions from audit will be monitored by MSPG with 6 monthly updates to ADTC
PGD	Annually – formic form sent to all areas that use PGD	Received by ADTC April 23 Planned for 2023/24	Actions from audit are monitored by PGD review group and updates to ADTC
Security of prescription stationery	Once in 5 years- sample of wards and departments across HSCP and ASD	Previous years work completed	Conducted by internal audit and monitored by Audit and Risk Committee. Assurance given to MSPG and ADTC

*Noting these will be reviewed as part of the review of the MAAP process

Summary of Actions

A workplan for the continued delivery of the High Risk Medicines Safety programme has been developed. Priorities for the coming 12 months are –

Action	Complete by
Review and improve use of the attractive stock dashboard. Develop ASD flowchart and guidance notes.	November 2024
Development and implementation of and attractive stock organisational action plan	December 2024
Continue to develop education and training resources to support staff with administration errors.	March 2025
Development and delivery of a package of improvement tools around controlled drugs	November 2025
Report to the Medicines Safety and Policy group to provide assurance of a learning system approach to medicines safety. It has a key role in the oversight of the Medicines Safety programme.	November 2025
Report to the Controlled Drug Governance Group provide assurance of a learning system approach to all CD incidents focusing on identifying key themes and actions for the organisation.	November 2025
Continue to develop education and training resources to support staff with administration errors.	Ongoing
A discharge audit tool was developed as part of the SSUMPP audit and assurance programme. An action plan is available and being implemented.	October 2024
A detailed analysis and action plan around extravasation incidents is underway with learning and actions to be shared.	December 2024
Review the Just in Case policy, and development of enhanced support to clinicians is underway.	October 2024
Develop a short life working group to look at the whole system approach to ordering and supply of medication (this is now incorporated into the Attractive Stock Organisational Action Plan).	December 2024
Review MAAP process.	December 2024
Focus on Anticoagulant Prescribing & Administration.	Ongoing
Focus on Lithium Prescribing & Management.	Ongoing
Focus on Insulin Prescribing & Administration.	Ongoing
Continue to develop and enhance our approach to prescribing of Sodium Valproate.	Ongoing
Focus on HRPM.	Ongoing

Actions completed from 2023 workplan –

Action
Review and improve use of the attractive stock dashboard. Monthly reviews are now in place.
Development and implementation of an improvement plan for insulin safety is underway.
A revised approach to analysis of supply incidents will be undertaken this year incorporating historic incidents and common learning/ themes, as part of the action plan for the Controlled Drugs Governance Group.
A working group has been established to review anticoagulant use to address any safety issues and support staff with education and training. This will be a core component of the medicines safety programme.
Development and delivery of a package of improvement tools around controlled drugs to support the MDT is underway.
Transformation of the function of the Safe and Secure use of Medicines Group to establish a learning system approach is underway, with a key role in the medicines safety programme.
Progress has been made on a detailed review of CD incidents within the CD governance group and refresh of the communications approach.

Pharmacy and Medicines Directorate

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 November 2024**
Title:	**Prevention and Control of Infection Annual Report 2023**
Responsible Executive:	**Janette Keenan, Director of Nursing and HAI-Executive**
Report Author:	**Julia Cook, Infection Control Manager**

Executive Summary

- During 2023 the IPCT experienced workforce challenges including recruitment and retention of staff, with workforce temporarily being added to risk register.
    - This position improved with the successful recruitment to the substantive posts Lead IPCN and IPCN in the later part of 2023.
    - Challenges continue with a vacancy in Consultant Microbiologists

- The Antimicrobial Team (AMT) group last met June 2022 due to resource pressures.
    - Reported recruitment challenges for an AMT Pharmacist

- Fife continues to comply with national mandatory surveillance requirements.

- Surgical Site Infection (SSI) – continued pause to national programme.

- *Escherichia coli* bacteraemia (ECB) surveillance continued during 2023. HCAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year
    - NHS Fife seen a decrease in both HCAI and CAI ECBs.

- *Clostridioides difficile* infection (CDI) HCAI and CAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year.
    - NHS Fife CDI rates although an increase was noted, NHS Fife continue at a level below the national Scottish average.

- The *Staphylococcus aureus* Bacteraemia (SAB) yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there were there were no increases or decreases in NHS boards, or in Scotland overall.
    - NHS Fife reported a slightly lower rate of HCAI and CAI SABs in 2023.

- 2023 saw 4 confirmed or suspected Norovirus outbreaks, 4 outbreaks of influenza and 76 COVID-19 clusters.

- Fife remains GREEN in the National Cleaning Specification monitoring reports.

- The Healthcare Environment Inspectorate, NHS Fife received 2 unannounced inspections:

- Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. 8th of February.
- Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

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 Clinical Governance Committee to provide assurance that all IPC priorities are being delivered as per the IPC Annual Work programme.

2.2 Background

IPCT 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

The SAB yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there were there were no increases or decreases in NHS boards, or in Scotland overall. NHS Fife reported a slightly lower rate of HCAI and CAI SABs in 2023

RESULTS
During the surveillance period there was a total of 90 SAB. 84 SAB were identified in the Victoria Hospital and four were acquired in Queen Margaret Hospital. One patient acquired their *S. aureus* bloodstream infection in Cameron hospital and a further patient was identified with a SAB under H@H.

- 88 (97.78%) were due to MSSA.
- 2 (2.22%) were due to MRSA.

Comments:

1. Compared to 2022 there has been a 2.1% decrease in the number of SAB.
2. In 2023 there were two (2.22%) MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
3. The proportion of VADs resulting in a hospital acquired SAB in 2023 was 26.47%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
4. One SAB was related to a with PVC infection. **NHS Fife has achieved the local improvement target** set by the ICC.
5. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB.
6. Areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices, skin & soft tissue infections plus people who inject drugs.
7. SAB where the entry point is not known remain a significant problem and accounted for 15.6% percent of the total in 2023

CDI

Clostridioides difficile infection (CDI) HCAI and CAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase in NHS Scotland overall from the previous year.

Locally, whilst NHS Fife & Fife Health & Social Care Partnership had seen a steady reduction in the number of CDI cases, there was a slight uptick in cases identified in 2023 (n=47). There were 19 hospital associated infection (HAI) CDI, 7 healthcare associated infections (HCAI) and 7 unknowns. Further to this, 14 CDI infections were community associated infections (CAI).

Management of recurrence of CDI for 2023;

- NHS Fife continue to use pulsed Fidaxomicin for CDI cases that are at high-risk of recurrence.
- Bezlotoxumab is now unavailable and exploring availability of commercial FMT as an alternative modality for managing recurrences alongside usual standard of care.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2024;

- Aim to consistently reinforce AMR in Board induction and teaching for GP trainees.
- Reiterate AMR best practice when clinicians call microbiology for advice and when CDI positive results are discussed
- Dissemination of surveillance
- Close monitoring and robust surveillance of cases in the community and acute healthcare settings.

ECB

Nationally during 2023 HCAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year

Locally, however NHS Fife seen a decrease in both HCAI and CAI ECBs during the surveillance period of 2023.

- there was a total of 235 ECB.
- There was a 15.2% decrease in the number of ECB in 2023 compared to 2022.
- In the hospital acquired infections, CAUTI, followed by hepatobiliary related infections were the most common source of ECB.
- In non-hospital acquired infections, the renal tract was the most common source.
- Catheters account for 25.7% of all healthcare associated infections (HAI+HCAI).

Recommendations- To reduce the total number of ECB, quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infections.

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 2023

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 4 new closures due to confirmed Influenza outbreak during this time period.

COVID-19

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

Hospital Inspection Team

There have been 2 inspections during 2023;

  - Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. 8th of February.
  - Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

IPCT continue 2 year rolling programme of audit with clinical teams undertaking monthly self SICPS audits.

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 achieving **Green** status.

Education & Training

The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach with a mix of e-learning via NES modules, Teams training and face-to-face training.

Quality Improvement

Initiatives include supportive works with the Catheter Improvement Group (UCIG). This multi-disciplinary and multi-agency programme works across all of Fife, both in the Acute Services Division (ASD) and the health and social care partnership (HSCP) to support a reduction in catheter associated urinary tract infections and catheter related complications.

Further quality improvement works continues with People Who Inject Drugs (PWID) SAB Project focus on supporting NHS Fife Addictions Service to complete and implement the agreed pathway for the assessment and treatment of injection site infections.

IPC Care Home Team

2023 focussed on collaborative working with care home managers and staff to ensure the service is supported in partnership. The IPC Care Home Team continued to provide support for all care homes in Fife to implement and facilitate IPC Standards and provide safe quality 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 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.

During 2023 the IPCT experienced workforce challenges including recruitment and retention of staff, with workforce temporarily being added to risk register.

- This position improved with the successful recruitment to the substantive posts Lead IPCN and IPCN in the later part of 2023.
- Challenges continue with a vacancy in Consultant Microbiologists

The Antimicrobial Team (AMT) group last met June 2022 due to resource pressures.

- Whilst not part of the IPCT there was a reported recruitment challenge for an AMT Pharmacist which impacts the AMT agenda.

IPCT resource challenges have been highlighted in the HAIRT report and to the ICC and HAI Executive, with assurance there have been interim measures introduced to ensure the safety of the service. This includes seeking supplementary staffing and offering additional hours to existing team members.

2.3.3 Financial

A potential cost pressures raised through SPRA and ADP.

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.

Infection Prevention & Control Committee

Executive Directors Group

2.4 Recommendation

- **Assurance** – This report provides a Moderate Level of Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Prevention & Control of Infection Annual Report 2023

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

NHS Fife Prevention and Control of Infection Annual Report 2023

Julia Cook Infection Control Manager

Approval Record	Date of Approval
NHS Fife Infection Control Committee	December 2024
NHS Fife EDG	October 2024
Chief Executive for NHS Fife Board	October 2024

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1.0 INTRODUCTION

Infection Prevention and Control Team (IPCT)

Julia Cook, Infection Control Manager
Amy Mbuli, Lead Infection Prevention and Control Nurse (from November 2023)
Elizabeth Dunstan, Senior Infection Prevention and Control Nurse
Mirka Barclay, Senior Infection Prevention and Control Nurse (HAI-SCRIBE and Built Environment)
Nykoma Hamilton, Infection Prevention and Control Nurse
Janice Barnes, Infection Prevention and Control Nurse
Catherine McCullough, Infection Prevention and Control Nurse (until October 2023)
Elaine Tate, Infection Prevention and Control Nurse
Ashley Norcross, Infection Prevention and Control Nurse
Pauline Young, Infection Prevention and Control Nurse
Nick Brough, Infection Prevention and Control Nurse (from November 2023)
Rosemary Shannon, Infection Prevention and Control Audit Nurse
Suzanne Watson, Senior Infection Prevention and Control Nurse (Care Homes)
Sharon Bernard, Infection Prevention and Control Nurse (Care Homes)
Jodie Gear, Infection Prevention and Control Nurse (Care Homes)
Lynsey Delaney, Infection Prevention and Control Surveillance Midwife
Kathleen Diamond, Clerical Officer
Beverley Young, Personal Assistant/Office Manager (until August 2023)
Sharon McDonald, Personal Assistant (from December 2023)

Consultant microbiologist	**Number of PAs**	
Dr Keith Morris	2	Provide clinical advice and chair ward outbreaks and incidents within the ASD. Responsible for alter organism surveillance Responsible for SAB, ECB and SSI surveillance and LDP targets
Dr Stephen Wilson	3	Clinical advice, HAI-SCRIBE, Water Safety, Ventilation and Decontamination
Dr Priya Venkatesh	4	IPC advice for HSCP, Oversee CDI surveillance and LDP targets for NHS Fife
Dr David Griffith	1	IPC general duties and AMT
Vacancy	3	General clinical advice
Total	13	

Celebrating Success

During 2023, the Infection Prevention and Control Service have:

- Continued to develop the IPC Care Home Team

- Support new IPC team members with post graduate study towards the MSc specialist practitioner qualifications in Infection Prevention and Control.

- NHS Fife IPC team have been supporting capital projects such as the National Treatment Centre for Elective Orthopaedic at the Victoria Hospital in Kirkcaldy

The team continued to develop the Infection Prevention and Control Service to;

- ✓ focus more on prevention than control
- ✓ sustain and build on achievements and strengths to date
- ✓ ensure that what works is implemented across the healthcare system
- ✓ support greater integration and partnership across the healthcare system
- ✓ ensure we prepare for the future and respond to emerging threats
- ✓ demonstrate our commitment to sustainable improvement
- ✓ promote a culture of zero tolerance of avoidable infections

The Board recognises our collective responsibility towards Healthcare Associated Infection (HCAI) risk and continuously supports our implementation of new initiatives to control these risks. Development, implementation and review of policies alongside surveillance and education are key components of the Infection Prevention and Control Team's proactive approach to addressing the HCAI agenda.

Prevention and control of infection is everyone's responsibility and, as a multidisciplinary team, every member of staff is dedicated to maintaining consistently high standards to ensure patients receive clean, safe care.

2.0 EXECUTIVE SUMMARY

- IPCT continues to work towards improving surveillance, prevention and control of healthcare associated infections across Fife through collaborative joint working.

- During 2023, the IPCT experienced workforce challenges including recruitment and retention of staff, with workforce temporarily being added to risk register. However, this position improved greatly with the successful recruitment to the substantive posts of Lead Infection Prevention and Control Nurse, 1 x Infection Prevention and Control Nurse and 1 x Personal Assistant in the later part of 2023.

- Fife continues to comply with national mandatory surveillance requirements.

- Surgical Site Infection (SSI) - pause to national programme.

- *Escherichia coli* bacteraemia (ECB) surveillance continued during 2023. HCAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year, however NHS Fife seen a decrease in both HCAI and CAI ECBs.

- *Clostridioides difficile* infection (CDI) HCAI and CAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year. NHS Fife rates continue at a level below the national Scottish average.

- The SAB yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there were there were no increases or decreases in NHS boards, or in Scotland overall. NHS Fife reported a slightly lower rate of HCAI and CAI SABs in 2023.

- 2023 saw 4 confirmed or suspected Norovirus outbreaks and 4 outbreaks of influenza.

- NHS Fife did experience incidents and clusters of COVID-19, with 76 incidents involving 2 or more patients and/or healthcare workers reported to ARHAI Scotland. This was a significant decrease from 2022 where there were 129 incidents. Staff demonstrated great commitment and effort working with the IPCT during outbreaks.

- Fife remains GREEN in the National Cleaning Specification monitoring reports.

- The Healthcare Environment Inspectorate, NHS Fife received 2 unannounced inspections:

    - Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife. QMH wards 1,2 and 4 and WMBH Ravenscraig ward on Wednesday 8th of February.
    - Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

- The AMT group last met June 2022 due to resource pressures.

NHS Fife has responded to the COVID-19 pandemic, by adopting the best evidence available, responded quickly and effectively to developments and changes in national guidance. Fife has made significant progress in the prevention and control of infection and the management of SAB, ECB and CDI HCAI during 2023, and responded quickly and effectively to developments and changes in national strategy. This will form a strong base from which to move forward on the challenges of the next twelve months.

Julia Cook, Infection Control Manager on behalf of the Infection Prevention and Control Team

3.0 PURPOSE OF REPORT

The purpose of this report is to provide information to the Infection Control Committee (ICC), Clinical Governance Committee (CGC), NHS Fife Board and all other interested parties on progress against the main objectives of the *Prevention & Control of Infection Work Programme (2022-23) and (2023-24),* and the management of COVID-19. The format ensures all elements that are required by the *NHS Health Improvement Scotland (HIS) IPC Standards (2022)* are included.

4.0 INFECTION CONTROL STRUCTURE AND ORGANISATION

4.1 Structures

Infection Control structure is defined within the *Prevention & Control of Infection Implementation Framework* which lays down individual responsibilities and committee accountability for delivery of Infection Prevention & Control in NHS Fife and the Health and Social Care Partnership.

In 2023, the IPCT reported through the NHS Fife Infection Control Committee (ICC), to the NHS Fife Clinical Governance Committee (NHSF CGC), the HSCP Clinical and Care Governance Committee and the Executive Directors Group (EDG). The ICC meets bi-monthly with minutes of the meeting being widely distributed.

NHS Fife has systems in place to ensure that national requirements for infection control, decontamination and cleaning as laid down in Chief Executive Letters (CEL), Chief Medical Officer for Scotland (CMO) letters, Chief Nursing Officer for Scotland (CNO) letters and other mandatory guidance are identified and addressed. These are disseminated direct to the Infection Control Manager (ICM) from the Scottish Government Health & Social Care Directorate (SGHSCD) Healthcare Associated Infection (HCAI) Policy unit or via the Chief Executive and the Executive Lead for Infection Prevention & Control.

4.2 Staffing and Resources

- Absence was a challenge during 2023, with long term sickness related absences impacted the service.
- Retention of staff in the IPC Care Home Team prove challenging, adding pressure on resources to allow for shadowing, mentoring and the orientation of new team members to build competency to undertake the care home team role autonomously.
- The IPCT was successful in recruiting to the substantive post of Lead Infection Prevention and Control Nurse from November 2023.

The challenges of COVID-19 have compelled the NHS to make the best use of our people's skills and experience, to provide safe and effective person-centred care. The IPCT has risen to the challenge and has been flexible and adaptable – with new ways of working such as MS Teams meetings training, and safety huddles. Infrastructure to enable staff to work from home has been facilitated by an increased investment in IT services and software.

IPCT resource challenges have been highlighted in the HAIRT report and to the ICC and HAI Executive, with assurance there have been interim measures introduced to ensure the safety of the service. This includes seeking supplementary staffing and offering additional hours to existing team members.

5.0 GOVERNANCE

5.1 Internal Audit

The IPCT did not receive any requests for review of IPC services, from the Internal Audit team for this reporting period.

6.0 NATIONAL STRATEGY

6.1 COVID-19 PANDEMIC RESPONSE

A coordinated hospital-wide approach was taken to infection prevention and control including close collaboration with ARHAI Scotland. The IPCT have provided NHS Fife and the HSCP with support and advice for health care workers involved in receiving, assessing and caring for patients who are a possible or confirmed case of COVID-19 in line with national guidance.

The IPC advice in response to the COVID-19 pandemic is based on the best evidence available from previous pandemic and inter-pandemic periods and the emerging evidence base on COVID-19 which is rapidly evolving. The IPCT have attended national meetings with ARHAI Scotland so as to be fully informed of the most up to date situation with COVID-19 and current national guidance.

The IPCT annual work plan was reviewed and COVID-19 response prioritised:

- An increase in frequency of IPCT ward/department visits
- Focus on education and training
- Focus on preventing infection in healthcare
- Support to clinical teams to investigate and implement control measures during outbreaks
- Participated in local and national COVID-19 meetings

During the pandemic the IPCT have been working collaboratively with key stakeholders and senior management teams.

Winter planning, outbreak management and supporting the seasonal influenza vaccination programme and the COVID-19 vaccination programme were a key focus for the IPCT to prepare for the winter season. With education and training provided to all levels of NHS Fife staff.

6.2 IPC Care Home Team

2023 focussed on collaborative working with care home managers and staff to ensure the service is supported in partnership. The IPC Care Home Team continued to provide support for all care homes in Fife to implement and facilitate the HIS IPC Standards (2022), the Care Home Infection Prevention and Control Manual (CH IPCM) and Care Home Cleaning Specification. Along with the review and implementation of Care Home Infection Prevention and Control (IPC) Resource for Gastro-intestinal and Care Home Infection Prevention and Control (IPC) Resource for Respiratory illness.

Support was identified through the team receiving referrals from the Health Protection Team (HPT), the Care Home Liaison Nurse Team (CHLNT) and directly from Care Home Managers.

Support offered to managers included an IPC walkabout, which identifies good practice and areas for improvement in regards to Standard Infection Control Precautions (SICPs). Education and training was offered for staff where managers felt this was required, based on feedback from the multidisciplinary team, Care Inspectorate (CI) and IPC walkabout findings. Other support given to care homes included signposting of relevant guidance and explanation and interpreting the guidance to promote best IPC practice.

Predominantly, Breaking the Chain of Infection, Hand Hygiene and Personal Protection Equipment (PPE) donning and doffing training was delivered to care homes in 2023 as well as bespoke training.

The IPC Care Home Team are currently working with the Health Protection Team (HPT) in reviewing scabies protocols when an outbreak occurs in a care home. This work is also being reviewed nationally and fed back to influence all local decisions.

Quality Improvement (QI) projects have also strengthened relationships with care home managers and improved professional collaborative relationships.

6.3 NHS HIS IPC Standards (May 2022)

NHS Fife received 2 Healthcare Improvement Scotland (HIS) inspections during 2023;

- **Healthcare Improvement Scotland (HIS): Unannounced Infection Prevention and Control Inspections of Mental Health Units Queen Margaret Hospital, NHS Fife.** QMH wards 1,2 and 4 and WMBH Ravenscraig ward on Wednesday 8th of February.

- 3 areas of good practice
- 7 requirements
- 2 recommendations

- **Healthcare Improvement Scotland (HIS): Safe delivery of care inspection - Unannounced inspection to Victoria Hospital, NHS Fife,** 31st of July- 2nd of August.

- 2 Recommendations
- 9 Requirements
- 4 areas of Good Practice

6.4 HAIRT reporting to Board

As part of the National HCAI Action Plan, all NHS Boards are required to provide a report on HAI during the public session of their bimonthly Board meetings, and to publish this on their website. A national HAI Reporting Template (HAIRT) produced by SGHSCD and revised in June 2010 has been used to update the NHS Fife Board. The report provides a spreadsheet of monthly case numbers and comparative data for ECB, CDI and SABs for individual acute hospitals, for community hospitals and for the community. It also highlights key actions and improvement work aimed at reducing these infections.

7.0 PROGRESS AGAINST INFECTION CONTROL PRIORITIES 2023

The Prevention and Control of Infection Work Programme 2023-24 is the NHS Fife delivery plan to comply with the national strategic objectives. The programme of work supports the National Quality Strategy ambitions as below.

National Quality Strategy ambitions Patient centred Control and prevention of HCAI measures will be proportionate and appropriate for the person receiving healthcare and the environment that healthcare is delivered. Safe A clean safe environment and the control and prevention of HCAI and antimicrobial resistance will reduce the risk of the population being exposed to or acquiring an HCAI (including resistant organisms) within any setting, that healthcare is delivered. Effective Control and prevention of HCAI measures and programmes, including prudent use of antimicrobial agents, surveillance, new technologies, education, training and research will support effective, equitable and consistent delivery of healthcare.

The *Prevention and Control of Infection Communications Plan 2021 - 2023* separately details how the Infection Prevention and Control Team communicate on a formal and informal basis with other colleagues, departments and the public.

7.1 Antimicrobial Prescribing and Resistance

AMR is a global concern. In January 2019, the UK Government published a vision for AMR in 20 years ‘Contained and controlled: The UK’s 20-year vision for antimicrobial resistance’ and a five-year national action plan ‘Tackling antimicrobial resistance 2019–2024’.

7.1.1 Antimicrobial Prescribing Guidelines

NHS Fife has an established antimicrobial management team (AMT) which reports to the NHS Fife Managed Services Drug and Therapeutic Committee, with minutes are provided to the ICC.

The AMT group last met June 2022 due to resource pressures.

The AMT has produced antimicrobial prescribing guidance since 2009 covering adult and paediatric prescribing in both primary and secondary care. Since 2014, the guidance is available as a Smartphone app and via a web viewer. Guidance is reviewed at least every 2 years but with the introduction of the app, it can now be updated instantly and this is done as required.

The aim of guidance is to restrict use of agents particularly associated with *Clostridioides difficile*, to limit the use of very broad-spectrum antimicrobial that may promote emergence of resistant strains, and to ensure that Scottish Antimicrobial Prescribing Group (SAPG) policy on hospital antimicrobial prescribing was met. Guidance considers local resistance data collected by the labs.

A protected antimicrobial list covering all wards has been in place since March 2009 and is updated annually or when required.

The antimicrobial pharmacist should maintain a database of all AMT guidelines with review dates to ensure they are reviewed every two years (or sooner if necessary), as per the most recent recommendation from SAPG. This activity has been necessarily displaced by activity related to the COVID-19 pandemic.

7.1.3 Antimicrobial Prescribing Education and Training

IPCT nurses promote the NES AMS module for nurses during induction and SICPs training. IPCNs provide 4 sessions online a year via Teams for AMS awareness. Information on the importance of appropriate antimicrobial use is communicated to all staff at NHS Fife Corporate Induction and Statutory Training.

7.1.4 Outpatient Parenteral Antimicrobial Therapy (OPAT)

The OPAT service contributes to prevention of healthcare-associated infections (such as MRSA and *Clostridioides difficile*) by allowing earlier discharge or admission avoidance for patients who would otherwise be confined to hospital solely for the delivery of intravenous antibiotic treatment.

The service also promotes the rational use of antimicrobials, and effective antimicrobial stewardship, through close clinical supervision by infection specialist doctors.

7.2 Cleaning, Decontamination and Estates

7.2.1 Cleaning and Estates Monitoring

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

The *National Cleaning Services Specification* – quarterly compliance report results for 2023 consistently showed NHS Fife achieving GREEN status for both cleaning and for estates monitoring. Results are reported bimonthly to the ICC via the HAIRT report.

7.2.2 Decontamination

The Decontamination Group meets quarterly and receives reports on primary care decontamination in dental Local Decontamination Units (LDU), endoscope decontamination in Endoscope Decontamination Units (EDU), and central decontamination delivered through a Service Level Agreement with Tayside CSSD.

7.2.2.1 Primary Care Decontamination

In NHS Fife, general practice instruments are either single-use or are decontaminated centrally and podiatry services moved to single –use instruments in 2010, so only dental services operate LDUs.

7.2.3 Estates - Equipment Procurement

Nominated IPCNs sit on National Procurement Commodity Advisory Panels (CAPs) and on Board procurement groups as part of NHS Fife's strategy for effective and safe procurement of a wide range of patient related equipment, soft furnishings, furnishings and medical devices.

7.2.3 Estates – Built Environment

The built environment plays a key role in the prevention and control of HCAI. This also includes pre-meetings and discussions. Systems to Control the Risk of Infection in the Built Environment (SCRIBE) are performed in all healthcare establishments. Initially aimed at new builds but include refurbishments and reconfigurations.

- Built environment plays a key role in the prevention and control of HAI
- Gives a holistic approach
- Challenges such as: technical advances, multi-resistant organisms
- Reduce cost in regards to people, work, money and clinical negligence

Throughout 2023, there continued to be a focus on reducing risk in the healthcare built environment - from the design, construction and adaptation phases of buildings and associated environments, to how they are occupied and maintained by the health care teams using them.

NHS Fife IPCT supported and provided IPC advice to 2 capital projects:

- NTC Fife Elective Orthopedic Centre
- Lochgelly and Kincardine Health Centers

The IPCT have worked collaboratively with NHSScotland Assure Assurance, to ensure an overarching focus on IPC and infection risk during all stages of the building lifecycle review

the design, construction and maintenance of major healthcare infrastructure developments within NHSScotland at key stages during the project lifecycle.

7.3 IPC Policy Guidance and Practice

7.3.1 Infection Control Manual

The NHS Scotland National Infection Prevention and Control Manual (NIPCM) first published on 13 January 2012, and was endorsed on 3 April 2017 by the Chief Medical Officer (CMO), Chief Pharmaceutical Officer (CPO), Chief Dental Officer (CDO) and Chief Executive Officer of Scottish Care.

The NIPCM provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS Scotland. In all other care settings to support with health and social care integration the content of this manual is considered best practice.

The NIPCM currently contains guidance on; Standard Infection Control Precautions (SICPs) (Chapter 1), Transmission Based Precautions (TBPs) (Chapter 2), Healthcare Infection incidents, outbreaks and data exceedance (Chapter 3). Infection control in the built environment and decontamination (Chapter 4). In addition to the core chapters, the NIPCM also contains multiple appendices and supporting materials which are constantly being updated as the evidence base evolves.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

The *NHS Fife Infection Control Manual* is available exclusively in electronic format on the NHS Fife StaffLink powered by Blink and NHS Fife external website.

As per **CNO (2012) 01**, Chapter 1 to 3 of the *National Infection Control Manual* are incorporated into the online NHS Fife manual with direct links. Further sections of the *National Infection Control Manual* will replace NHS Fife chapters as they are published.

Implementation of policy elements is monitored through the Infection Prevention and Control Team audit programme and Senior Charge Nurses fulfil the requirements for SICPs auditing laid down in **CNO (2012) 01** and later modified by the CNO letter of 17 May 12.

Manual sections sit under the overarching Infection Control Policy with the status of Standard Operating procedures (SOPs) which are updated on a rolling programme (every two years in line with HIS IPC Standards 2022).

7.3.2 HCAI Education, Training and Development Strategy: Mandatory and Continuing Education

The *HCAI Education, Training and Development Strategy* was developed to ensure that all staff had access to appropriate HCAI education and training. (Line managers are required to ensure all staff have HCAI objectives in their annual personal development plans).

The IPCT have strived to provide NHS Fife and Care Home staff with IPC education and training via a blended learning approach with face-to-face training. The IPCT have actively promoted the NES modules, which include eLearning- Respiratory protective equipment (RPE), presentations and webinars on COVID-19 and IPC.

IPCT have collaborated on several training presentations on topics relevant to staff, including outbreaks and terminal cleans. The presentations have been recorded with a voice over, available on StaffLink and can be accessed by all NHS Fife staff.

Throughout 2023, the IPCT have delivered education sessions via Microsoft Teams, face to face session and training at ward/department level.

HCAI education is a core component of corporate induction, nurse induction, junior doctors' induction, Consultant Mandatory Programme, and Core Update training programmes and is available as an e-learning module(s) on TURAS Learn. All NES developed e-learning programmes are available to staff on TURAS Learn.

7.3.3 Hand Hygiene

7.3.3.1 Trends

Publication of National Hand Hygiene Audit data ceased in Sept 2013 with Boards moving to reporting of data in their bimonthly HAIRT reports.

The IPCT carry out Hand Hygiene quality assurance audits as part of the *HCAI Prevention and Control of Infection Assurance Framework*.

7.4 Organisational Structures

7.4.1 Public Involvement

A member of the public has historically been invited to sit on the NHS Fife ICC and contribute to the outcomes of the committee, this position has been vacant and new ways of ensuring public feedback on IPC is under consideration.

7.4.2 Communications

The IPCT has a *Prevention and Control of Infections Communications Plan*, which has been in place since June 2011 (updated accordingly). NHS Fife recognises the importance of having a comprehensive set of accurate, relevant and accessible information available for patients and the public. During the year, NHS Fife Communications Team has played a

vital role in providing essential communications to the patients, visitors and population of Fife during the COVID-19 pandemic. Patient and public information leaflets on MRSA, *Clostridioides difficile,* Norovirus, Laundering of Patient Clothing, and Infection Control advice for Patients & Visitors have continued to be provided to wards and clinical areas. Leaflets on peripheral vascular devices, Vancomycin Resistant *Enterococcus* (VRE), Carbapenemase Producing *Enterobacteriaceae* (CPE) and MRSA screening are provided on a targeted basis to patients affected by these issues.

In addition to hard copy leaflets distributed to wards and clinics, these have been made available online to ensure that they are available for staff to use when briefing patients and visitors. Translation services are available on request.

In response to HEI requirements, and to ensure that all patients are provided with relevant HCAI information on admission, the general Infection Prevention and Control advice for Patients & Visitors leaflet is available to all clinical areas for distribution. Banner-stand posters aimed at both staff and visitors reinforce key HCAI messages.

7.5 Staff and Leadership

7.5.1 Structures and accountabilities

In October 2015, the IPCT was reorganised to comply with the *Vale of Leven Public Enquiry Report (2014)* recommendations. The IPC team returned to single system working managed by an Infection Control Manager with responsibility for a Fife wide service.

7.6 Quality Improvement

7.6.1 *Quality Improvement Programmes and partnership working with the Scottish Patient Safety Partnership (SPSP)*

During 2023, the IPCT worked collaboratively to support improvements in Urinary Catheter Care via the Urinary Catheter Improvement Group (UCIG).

UCIG update for 2023

To support a reduction in Catheter Associated Urinary Tract Infections & complications and to assist achieving the HCAI *E. coli* bacteraemia (ECB) reduction targets by 2022 & 2024, Fife established a Urinary Catheter Improvement Group (UCIG).

This multi-disciplinary and multi-agency programme works across all of Fife, both in the Acute Services Division (ASD) and the health and social care partnership (HSCP).

The aim of this work is:

- To minimise the incidence of urinary catheters
- To reduce avoidable harm from urosepsis and associated catheter trauma
- To optimise communication of care between all care disciplines & locations
- To optimise education around urinary catheter insertion & maintenance for health care workers, patients & carers
- To optimise documentation of urinary catheter care across Fife

- To improve quality & standardise pathways of urinary catheter care across the system
- To optimise the procurement of catheters & associated devices
- To ensure governance for all urinary catheters to ensure there is robust, accessible, consistently applied and measures (process and outcome) are reported reliably and consistently to provide assurance and data for improvement.

People Who Inject Drugs (PWID) SAB Project Update for 2023

A significant increase in the total number of SAB infections were identified in people who inject drugs (PWID) in 2023. 11 cases in total were identified, the same as 2022, but higher than the 4 cases identified in 2021. The IPCT aim for 2023 was to focus on supporting NHS Fife Addictions Service to complete and implement the agreed pathway for the assessment and treatment of injection site infections. This included refresher training via an online presentation accessed by individuals in the service and support with the re-implemention of the injection site assessment questionnaire, this work continues.

7.7 Surveillance

7.7.1 Surgical Site Infection (SSI)

A CNO letter on 25 March 2020 advised of changes to HAI surveillance requirements with temporary changes to routine surveillance:

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

7.7.1.1 Caesarean section

Due to the COVID-19 pandemic, there has been a temporary pause on SSI surveillance, until further notice from Scottish Government. Maternity Services have continued to monitor their Caesarean Section SSI cases liaising with the IPCT.

7.7.1.2. Hip Arthroplasty

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

7.7.1.3. Large Bowel

All Large Bowel surveillance has been postponed due to the COVID19 pandemic until further notice as per CNO letter

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

For *E. coli* bacteraemia (ECB)

- New LDP standards are to reduce incidence of healthcare associated ECB by **25%** from 2019 to 2024, utilising 2018/19 as baseline data

Table 1: **25% reduction ECBs - 2023**

1) 25% reduction ECBs – 2023/24		
New standards for reducing all Healthcare Associated ECB by 25% by 2023/24 (from 2018/2019 baseline)		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2024**
ECB by rate 100,000 TBDs	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**

For *Clostridioides difficile* infection (CDI)

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

Table 2: **New standards for reducing all Healthcare Associated CDI by 10% by 2024 (from 2018/2019 baseline)**

New standards for reducing all Healthcare Associated CDI by 10% by 2024 (from 2018/2019 baseline)		
Standards application for Fife:	**CDI Rate Baseline 2018/2019**	**CDI 10% reduction target by 2024**
CDI by rate 100,000 Total bed days	**7.2** per 100,000 TBDs	**6.5** 100,000 TBDs
CDI by Number of HCAI cases	**26**	**23**

For *Staphylococcus aureus* bacteraemia (SABs)

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

Table 3: **New standards for reducing all Healthcare Associated SAB by 10% by 2024 (from 2018/2019 baseline)**

New standards for reducing all Healthcare Associated SAB by 10% by 2024 (from 2018/2019 baseline)		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2024**
SAB by rate 100,000 Total BDs	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**

7.7.2 Escherichia coli Bacteraemia (ECB)

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli,* and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals, care homes, under social care and the wider community.

Nationally during 2023 HCAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase NHS Scotland overall from the previous year

Locally, however NHS Fife seen a decrease in both HCAI and CAI ECBs during the surveillance period of 2023 there was a total of 235 ECB. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

COMMENTS

- There was a 15.2% decrease in the number of ECB in 2023 compared to 2022.
- The age range for an *E.coli* bloodstream infections is skewed towards the over 60s with the peak of infections occurring in the age range 70-79 years of age.
- In the hospital acquired infections, CAUTI, followed by hepatobiliary related infections were the most common source of ECB.
- In non-hospital acquired infections, the renal tract was the most common source.
- Hospital patients account for 17.9% of the total ECB. This is up from 16.4% in 2022.
- Catheters account for 25.7% of all healthcare associated infections (HAI+HCAI). Reducing ECB to achieve the LDP will require infection prevention measures in hospitals and in the Health and Social Care Partnerships to reduce CAUTI.

Recommendations

- To reduce the total number of ECB and reduce hospital admissions, quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infections: to prevent these infections developing into bloodstream infections
  (See Appendix 1: ECB Annual report for full details)

7.7.3. *Clostridioides difficile Infection* (CDI)

Clostridioides difficile is a bacterium found in people's intestines. Healthy people may have in gut flora, where it causes no symptoms. However, it may cause disease when the normal bacteria in the gut are disadvantaged, usually by antibiotics. When *C. difficile* is able to multiply this allows its toxins to reach levels where it attacks the intestines and causes mild to severe diarrhoea. *C. difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel.

Clostridioides difficile infection (CDI) HCAI and CAI yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there was an increase in NHS Scotland overall from the previous year.

Locally, whilst NHS Fife & Fife Health & Social Care Partnership had seen a steady reduction in the number of CDI cases, there was a slight uptick in cases identified in 2023 (n=47). NHS Fife rates however, continue at a level below the national Scottish average. Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

RESULTS
Between 1st January and 31st December 2023 there were a total of 47 cumulative episodes of CDI in patients aged $\geq$ 15 years in Fife.
There were 19 hospital associated infection (HAI) CDI, 7 healthcare associated infections (HCAI) and 7 unknowns. Further to this, 14 CDI infections were community associated infections (CAI).
(Appendix 3: CDI Annual Report 2023).

COMMENTS

1. Compared to 2022, there has been a 14.8% increase in the total number of CDIs
2. The proportion of hospital acquired CDI in 2023 was 40%
3. 95% HAI cases had previous (in the 12 weeks prior to CDI) antibiotic use as a risk factor for CDI
4. In 2023 there were 4 recurrences in CDI and 5 cases of previous infection

Management of recurrence of CDI for 2023
NHS Fife continue to use pulsed Fidaxomicin for CDI cases that are at high-risk of recurrence.
Bezlotoxumab is now unavailable and exploring availability of commercial FMT as an alternative modality for managing recurrences alongside usual standard of care.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2024
Focus on Antimicrobial Stewardship and AMR practices
Aim to consistently reinforce AMR in Board induction and teaching for GP trainees.
Reiterate AMR best practice when clinicians call microbiology for advice and when CDI positive results are discussed with clinicians.
Dissemination of surveillance data through newsletters to raise awareness to GPs of CDI rates and importance of prudent antimicrobial prescribing.
Close monitoring and robust surveillance of cases in the community and acute healthcare settings.

7.7.4 *Staphylococcus aureus Bacteraemia (SAB)*

Staphylococcus aureus is a bacterium that commonly exists on human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. If the bacteria enter the body, illnesses, which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves, pneumonia and blood stream infection (bacteraemia).

Nationally during 2023 the SAB yearly trends (comparing year-ending December 2022 with year-ending December 2023) show that there were there were no increases or decreases in NHS boards, or in Scotland overall. NHS Fife reported a slightly lower rate of HCAI and CAI SABs in 2023

RESULTS
During the surveillance period there was a total of 90 SAB. 84 SAB were identified in the Victoria Hospital and four were acquired in Queen Margaret Hospital. One patient acquired their *S. aureus* bloodstream infection in Cameron hospital and a further patient was identified with a SAB under H@H.

- 88 (97.78%) were due to MSSA.
- 2 (2.22%) were due to MRSA.

COMMENTS

1. Compared to 2022 there has been a 2.1% decrease in the number of SAB.
2. In 2023 there were two (2.22%) MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
3. The proportion of hospital acquired SAB in 2023 was 37.78% which was slightly more than the 35.9% in 2022
4. The proportion of VADs resulting in a hospital acquired SAB in 2023 was 26.47%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. One SAB was related to a with PVC infection. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug increased from 10 in 2022 to 11 in 2023.
7. Figures 2 & 5 indicate the areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices, skin & soft tissue infections plus people who inject drugs.
8. SAB where the entry point is not known remain a significant problem and accounted for 15.6% percent of the total in 2023

   (See Appendix 2: Annual SAB Report for full details).

- ***7.7.5 National MRSA and CPE screening programme***

The MRSA Screening Key Performance Indicator (KPI) for 2023 remains set as '*90% of all acute admissions must have CRA within 24 hrs of admission'.*

Table 6: MRSA CRA Compliance to end 2023

MRSA

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

Quarter	Q1 2023 Jan-Mar	Q2 2023 April-June	Q3 2023 Jul-Sept	Q4 2023 Oct-Dec
Fife	100%	98%	93%	100%
Scotland	78%	81%	80%	74%

Table 7: CPE CRA Compliance to end 2023

CPE (*Carbapenemase Producing Enterobacteriaceae*)				
For 2023, CRA has also included screening for CPE				
Quarter	**Q1 2023 Jan-Mar**	**Q2 2023 April-June**	**Q3 2023 Jul-Sept**	**Q4 2023 Oct-Dec**
Fife	100%	100%	100%	**100%**
Scotland	77%	80%	81%	76%

Compliance with MRSA and CPE CRA completion fluctuates however is predominantly above the Scottish national average and continuously well above the 90% compliance target in 2023 (Table 6 & 7). With the IPC worked closely with Excellence in Care and Digital Information, developed a national tool for Multi-Drug Resistant Organisms surveillance, which is be used locally. This tool supports a consistent pathway for the clinical risk assessment of patients and patient placement.

7.7.7 Outbreaks and Incidents

7.7.7.1 Norovirus

The year of 2023 saw 4 outbreaks of Norovirus or suspected norovirus with pathogen unknown.

7.7.7.2 Other Outbreaks

For the year of 2023 there were 4 wards/bays closed due to Influenza.

7.7.7.3 COVID-19 Clusters and Incidents related to healthcare

The IPCT provided support to clinical teams to investigate and implement control measures during the COVID-19 pandemic which saw a significant increase in incidence of COVID-19 respiratory illness. There were 76 incidents/clusters that involved patients and/or healthcare workers, this was a significant decrease from the 129 outbreaks the previous year.

7.7.8 Infection Control Audits

The IPC audit programme provides assurance to the organisation that the required HAI standards are being met board wide. The focus is on intelligence led auditing which will assist in validating the ward level audit programme and ensure a consistent approach is taken.

A two-year rolling programme was initially commenced in August 2016 and again in 2018; which encompasses all divisions and a wide range of clinical areas.

The IPC nurses prioritise areas where issues with compliance have been identified through either observation or other assurance processes provided by other services within the board.

Monitoring and reporting of Estates issues is conducted by the domestic teams as part of NHS Scotland National Cleaning Standards monitoring and Quality Assurance team undertake additional audits.

Auditing of Standard Infection Control Precautions including hand hygiene is the responsibility of Senior Charge Nurses (SCNs).

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Appendix 1:
Annual report: *E. coli* bacteraemias (ECB) in NHS Fife from 1st January 2023 to 31st December 2023
Dr Keith Morris, Microbiologist & Infection Control Doctor

INTRODUCTION
The report demonstrates the *E. coli* bacteraemia (ECB) epidemiology in 2023. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *E. coli* bacteraemia.

Data for this report has been obtained from surveillance carried out by consultant microbiologists and the Infection Control Surveillance Audit Midwife in NHS Fife. During the surveillance period there was a total of 235 ECBs. Bloodstream infections with *E. coli* are widespread in NHS Fife and were identified in patients in hospitals care homes, community and under social care.

The ECB epidemiology in this report occurred following the SARS-CoV-2 pandemic and must be considered in this environment. During this time services were in a recovery period and this may have influenced the number of hospital acquired ECB.

RESULTS
Between 1st January and 31st December 2023 there were 235 episodes of ECB. 115 occurred in males (49%) and 120 occurred in females (51%). Figure 1 demonstrates the trend in the number of ECBs over the last eight years split by gender.

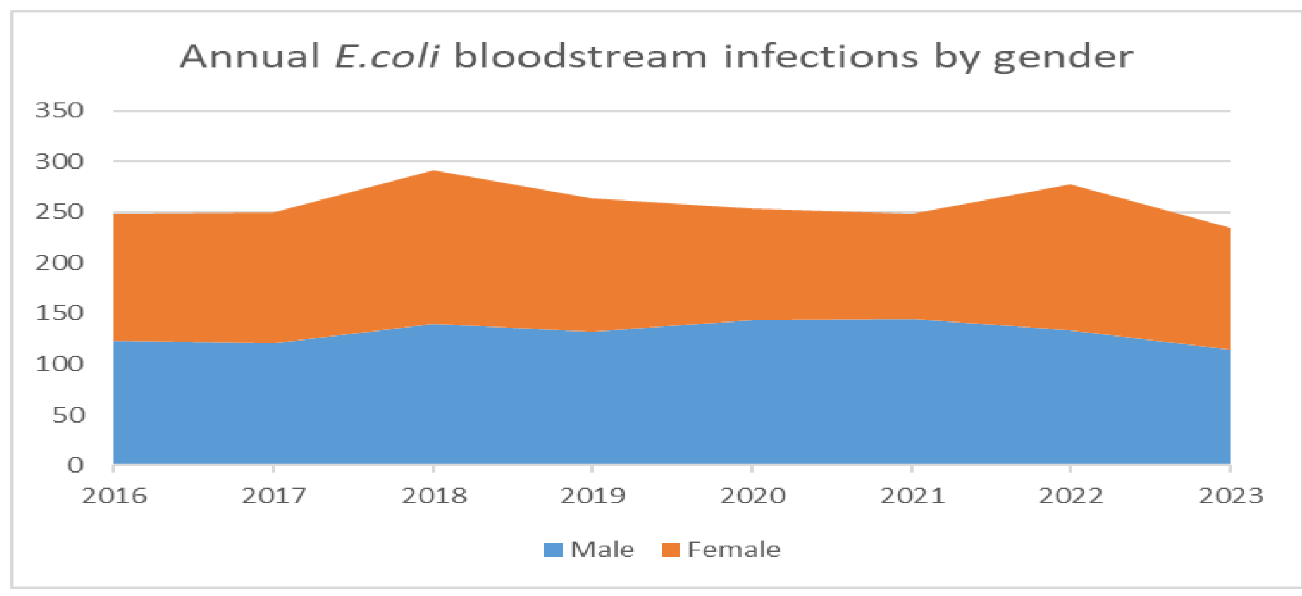


Figure 1: Trend in ECB by gender

Appendix 1 demonstrates that gender does have a role to play in the entry points for ECB. Males are more likely to have a urethral catheter as the cause of an ECB, whilst renal tract as an entry point is more common in women.

Figure 2 demonstrates that the number of ECB increases with age.

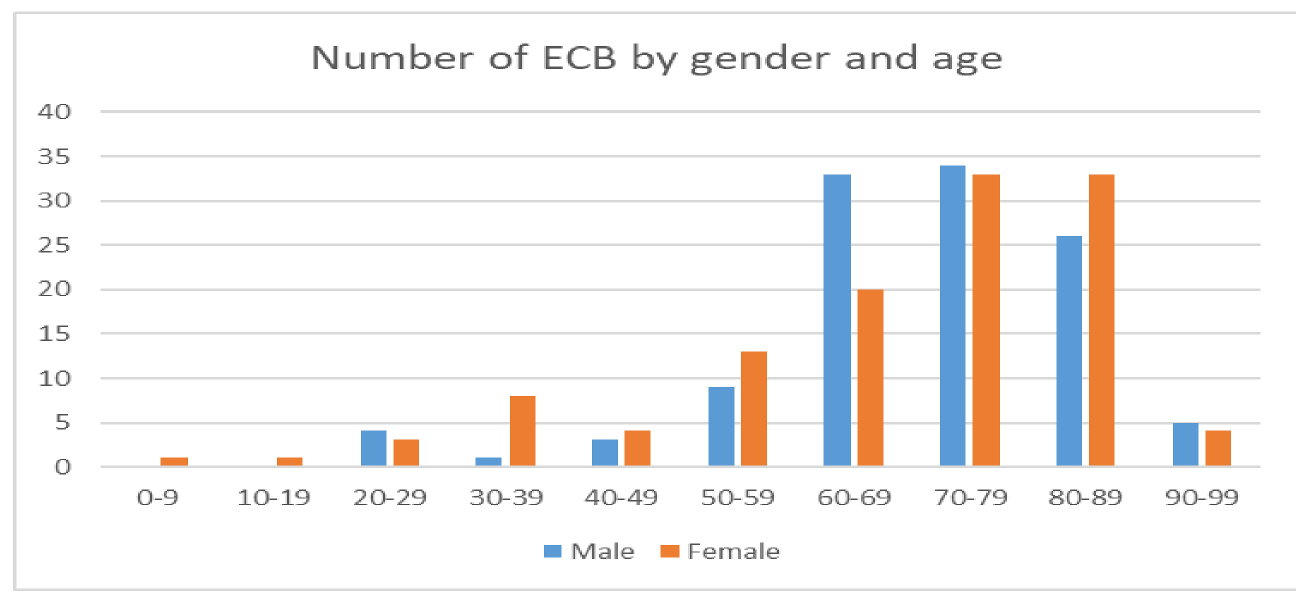


Figure 2 number of ECB by decade of life

42 (17.9%) of ECB episodes were hospital acquired and 193 (82.1%) were non hospital acquired. Non hospital ECB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections.

Figure 3 demonstrates the trend between hospital acquired and non-hospital ECB over the last eight years.

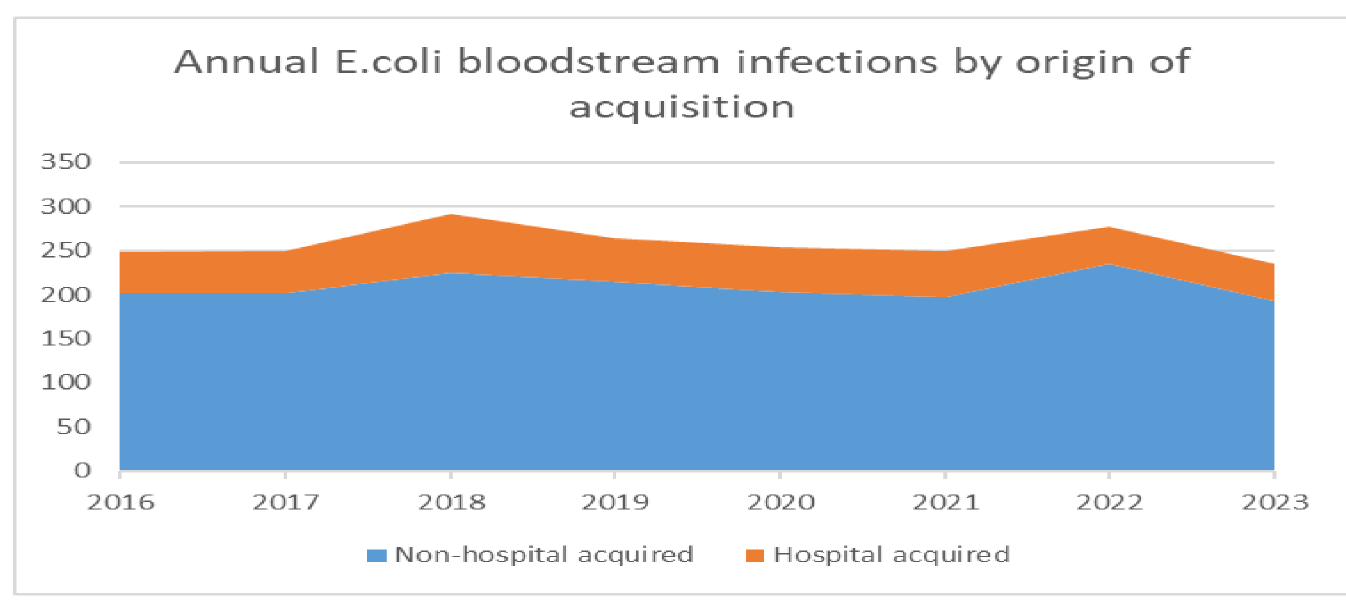


Figure 3: Annual ECB by origin of acquisition

Figure 4 presents data on the entry point of each hospital acquired ECB by system during 2023.

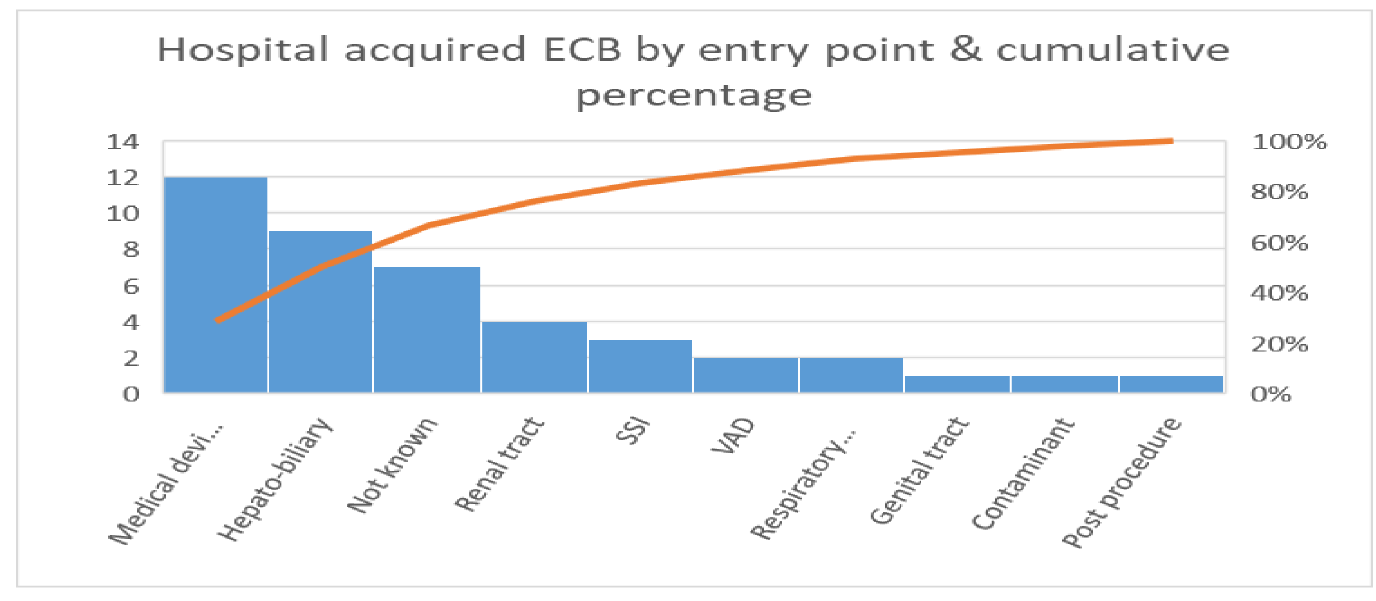


Figure 4: Pareto chart demonstrating the entry point by system of each hospital acquired ECB. More detail on the source of each ECB can be found in appendix 1.

Regarding hospital acquired infections; two of the renal tract infections were due to lower urinary tract infection, one was caused by pyelonephritis and the other by cystitis. With regards to the medical device related ECBs; eleven of the cases were due to urinary catheters and the remaining one was associated with a nephrostomy.

Figure 5 presents data on the entry point of each non hospital acquired ECB episode during 2023.

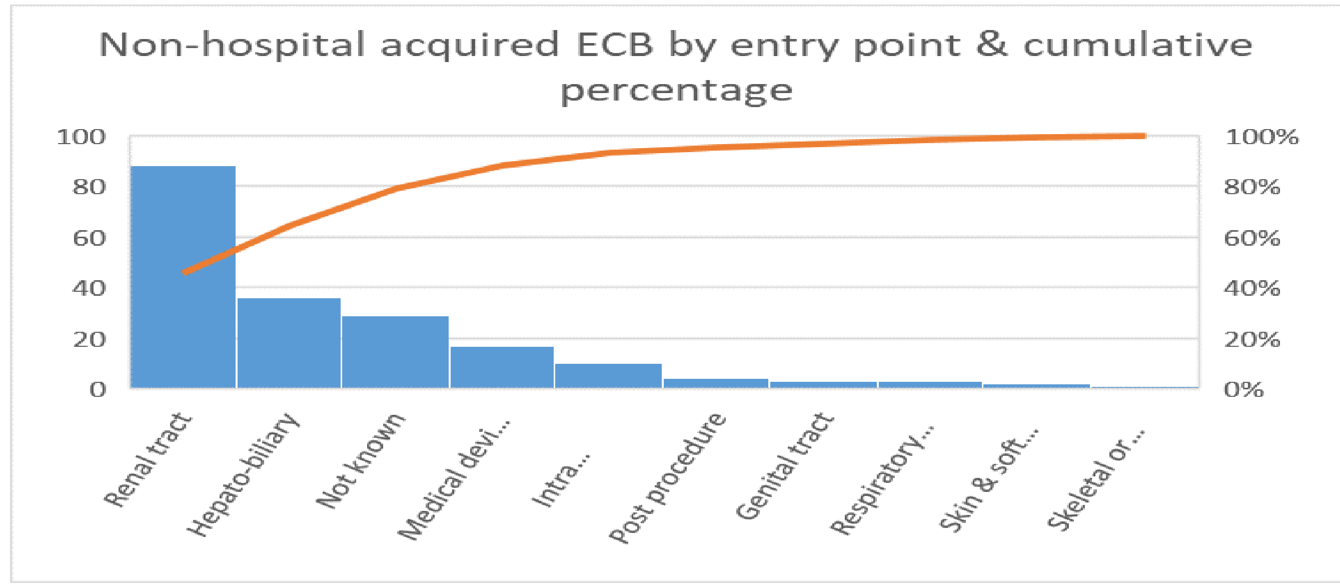


Figure 5: Pareto chart demonstrating the entry point by system of each non hospital acquired SAB.

Regarding the non-hospital acquired ECB; 34 of the renal tract infections were due to lower UTI, 21 were caused by cystits, a further 21 by pyelonephritis, 3 by hydronephrosis and 9 by `other`. There were 17 medical device related infections. 13 were due to urethral catheters and 4 were due to suprapubic catheters.

COMMENTS

- There was a 15.2% decrease in the number of ECB in 2023 compared to 2022.
- The age range for an *E.coli* bloodstream infections is skewed towards the over 60s with the peak of infections occurring in the age range 70-79 years of age.
- In the hospital acquired infections, CAUTI, followed by hepatobiliary related infections were the most common source of ECB.
- In non-hospital acquired infections, the renal tract was the most common source.
- Hospital patients account for 17.9% of the total ECB. This is up from 16.4% in 2022.
- Catheters account for 25.7% of all healthcare associated infections (HAI+HCAI). Reducing ECB to achieve the LDP will require infection prevention measures in hospitals and in the Health and Social Care Partnerships to reduce CAUTI.
- To reduce the total number of ECB and reduce hospital admissions, quality improvement programs need to focus on greater awareness and improved management of UTI, CAUTIs and hepato-biliary infections: to prevent these infections developing into bloodstream infections.

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). The letter set out a reduction of 50% in healthcare associated E. coli bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22. 2018/19 should be used as the baseline for E. coli bacteraemia reduction. In the letter healthcare associated ECB includes hospital acquired infections plus healthcare associated infections.
In March 2023 a new DL was issued (DL(2023) 06) which reset the LDP as 25% reduction in healthcare associated ECB by 31st March 2024.
For the period 1st Apr 2018 to 31st Mar 2019 there were 160 healthcare associated ECB. Therefore 25% of 160 is 40. To achieve the LDP 25% reduction target there should be no more than 120 healthcare associated ECB for the period 1st Apr 2023 to 31st Mar 2024.

Appendix 1

System involved split by gender 2023

System	Female	Male	Grand Total
Contaminant	0	1	1
Genital tract	3	1	4
Hepato-biliary	17	28	45
Intra-abdominal	3	7	10
Medical device	8	21	29
Not known	22	14	36
Skeletal or joint infection	1	0	1
Post procedure	1	4	5
VAD	1	1	2
Renal tract	59	33	92
Respiratory tract	2	3	5
Skin & soft tissue	1	1	2
SSI	2	1	3
Grand Total	**120**	**115**	**235**

Appendix 2
Entry point for each ECB episode by origin 2023

System	CAI	%	HCAI	%	HO	%	?HCAI or community	%	Grand Total	%
Contaminant		0		0	1	2.38	0	0	1	0.43
Genital tract	1	0.82	2	2.82	1	2.38	3	1.55	4	1.70
Hepato-biliary	29	23.77	7	9.86	9	21.43	36	18.65	45	19.15
Intra-abdominal	8	6.56	2	2.82	0	0	10	5.18	10	4.26%
Medical device	0	0	17	23.94	12	28.57	17	8.80	29	12.34
Not known	10	8.20	19	26.76	7	16.67	29	15.03	36	15.32
Skeletal or joint infection	1	0.82	0	0	0	0	1	0.52	1	0.43
Post procedure	0	0	4	5.63	1	2.38	4	2.07	5	2.13
VAD	0	0	0	0	2	4.76	0	0	2	0.85
Renal tract	71	58.20	17	23.94	4	9.52	88	45.60	92	39.15
Respiratory tract	2	1.64	1	1.41	2	4.76	3	1.55	5	2.13
Skin & soft tissue	0	0	2	2.82	0	0	2	1.04	2	0.85
SSI	0	0	0	0	3	7.14	0	0	3	1.28
Grand Total	**122 (51.9 % of total cases)**	**100%**	**71 (30.2 % of total cases)**	**100%**	**42 (17.9 % of total cases)**	**100%**	**193 (82.1 of total cases)**	**100%**	**235**	**100%**

*The numbers in red highlight the three most common ECB by system

Appendix 2:

Annual report: *S. aureus* bacteraemias (SAB) in NHS Fife from 1st January 2023 to 31st December 2023

Dr Keith Morris, Consultant Microbiologist & Infection Control Doctor

INTRODUCTION

The report demonstrates the *S. aureus* bacteraemia (SAB) epidemiology in NHS Fife in 2023. The Infection Control Committee are asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of *S. aureus* bacteraemias.

Data for this report has been obtained from surveillance carried out by Dr Morris & Dr Griffith. During the surveillance period there was a total of 90 SAB. 84 SAB were identified in the Victoria Hospital and four were acquired in Queen Margaret Hospital. One patient acquired their *S. aureus* bloodstream infection in Cameron hospital and a further patient was identified with a SAB under H@H.

RESULTS

Between 1st January and 31st December 2023 there were 90 episodes of SAB. 88 (97.78%) were due to MSSA. There were two (2.22%) were due to MRSA. Figure 1 demonstrates the trend of SAB over the previous 15 years.

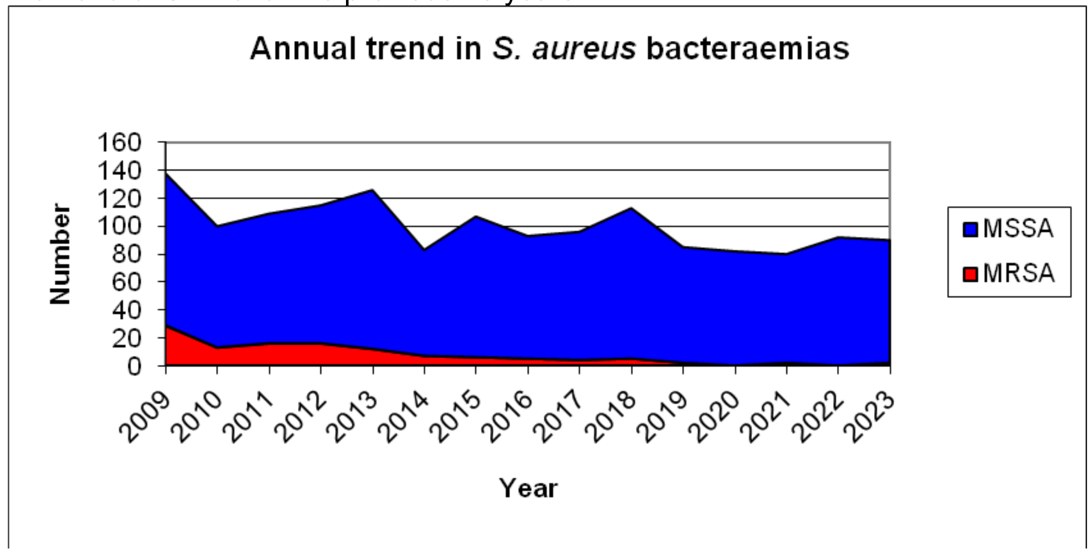


Figure 1: Trend in SAB

34 (37.78%) of SAB episodes were hospital acquired and 56 (62.22%) were non hospital acquired. Non hospital SAB can be divided into Healthcare Associated Infection (HCAI) and community acquired infections. Table 1 Demonstrates the age and gender of patients with a hospital or non hospital acquired SAB

	Hospital acquired infection* (*n*=34) 37.78%	Healthcare associated infection* (*n*=13) 14.44%	Community Acquired infection* (*n*=43) 47.78%	Total SAB (*n*=90)
	n (%)	n (%)	n (%)	n (%)
Male	22 (64.71)	9 (69.23)	30 (69.77)	61 (67.78)
Female	12 (35.29)	4 (30.77)	13 (30.23)	32 (32.22)
Age:mean (Range) years	63.3 (0-92)	68.0 (25-94)	59.1 (5-92)	66.2 (0–95)
MRSA	1	0	1	2 (2.22)
MSSA	33	13	42	88 (97.78)

Table 1 Age, sex and susceptibility to meticillin of each SAB by origin

*The origin of a SAB is defined in the Enhanced *S. aureus* Bacteraemia Surveillance Protocol April 2016, Version 1.0

Figure 2 presents data on the entry point of each hospital acquired SAB during 2023.

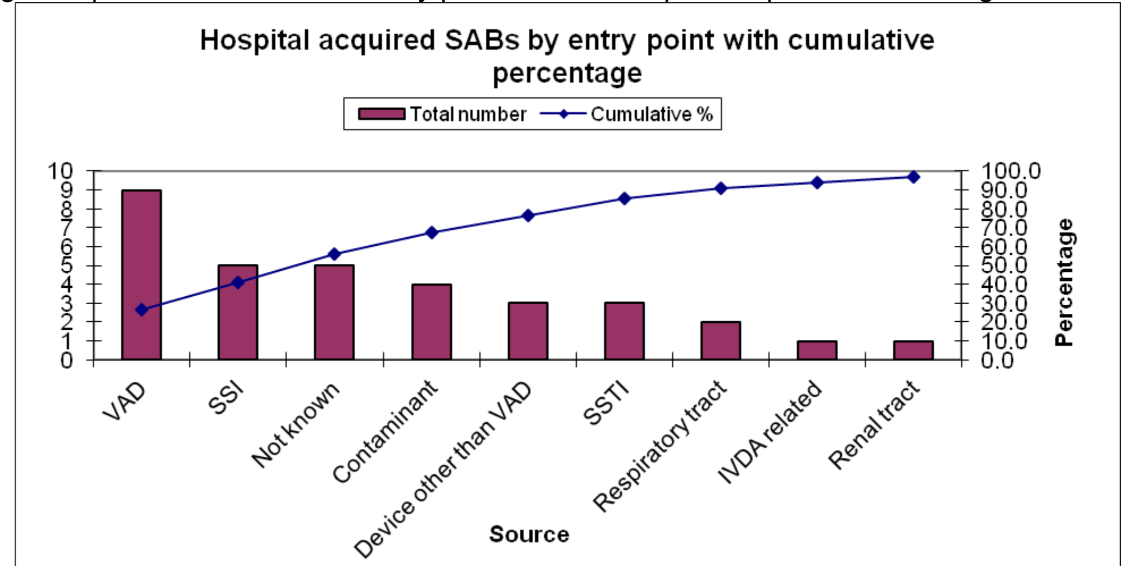


Figure 2: Pareto chart demonstrating the entry point of each hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection, SSI=surgical site infection.

More detail on the source of each SAB can be found in appendix 1.

Figure 3 provides a breakdown of the different types of vascular access device for every hospital acquired SAB episode where a VAD was identified as the entry point for the bacteraemia.

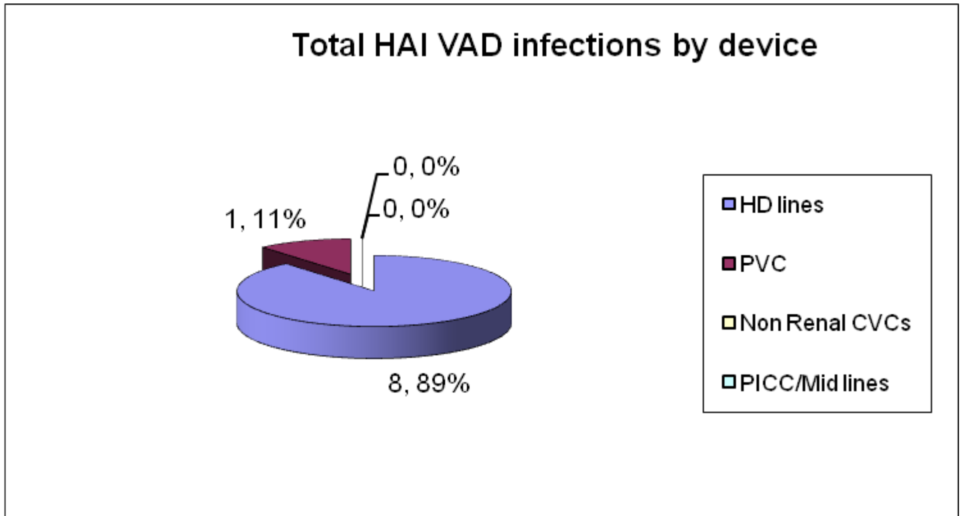


Figure 3: Types of VAD infection in 2023. PVC=peripheral vascular catheter, HD=haemodialysis, CVC-central venous catheter. PICC=peripherally inserted central catheter

Figure 4 demonstrates the trend in hospital acquired SAB over the last five years in relation to the entry point for the bacteraemia.

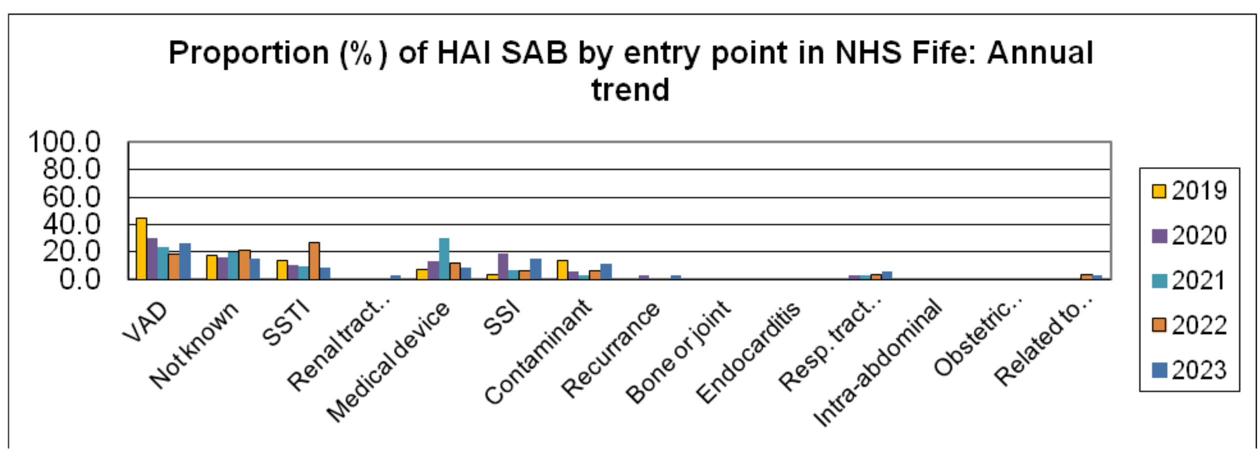


Figure 4: Trend in the entry point of hospital acquired SAB over five years. VAD=vascular access device, Not known=entry point not identified, SSTI=soft tissue infection, SSI=surgical site infection

Figure 5 presents data on the entry point of each non hospital acquired SAB episode during 2023.

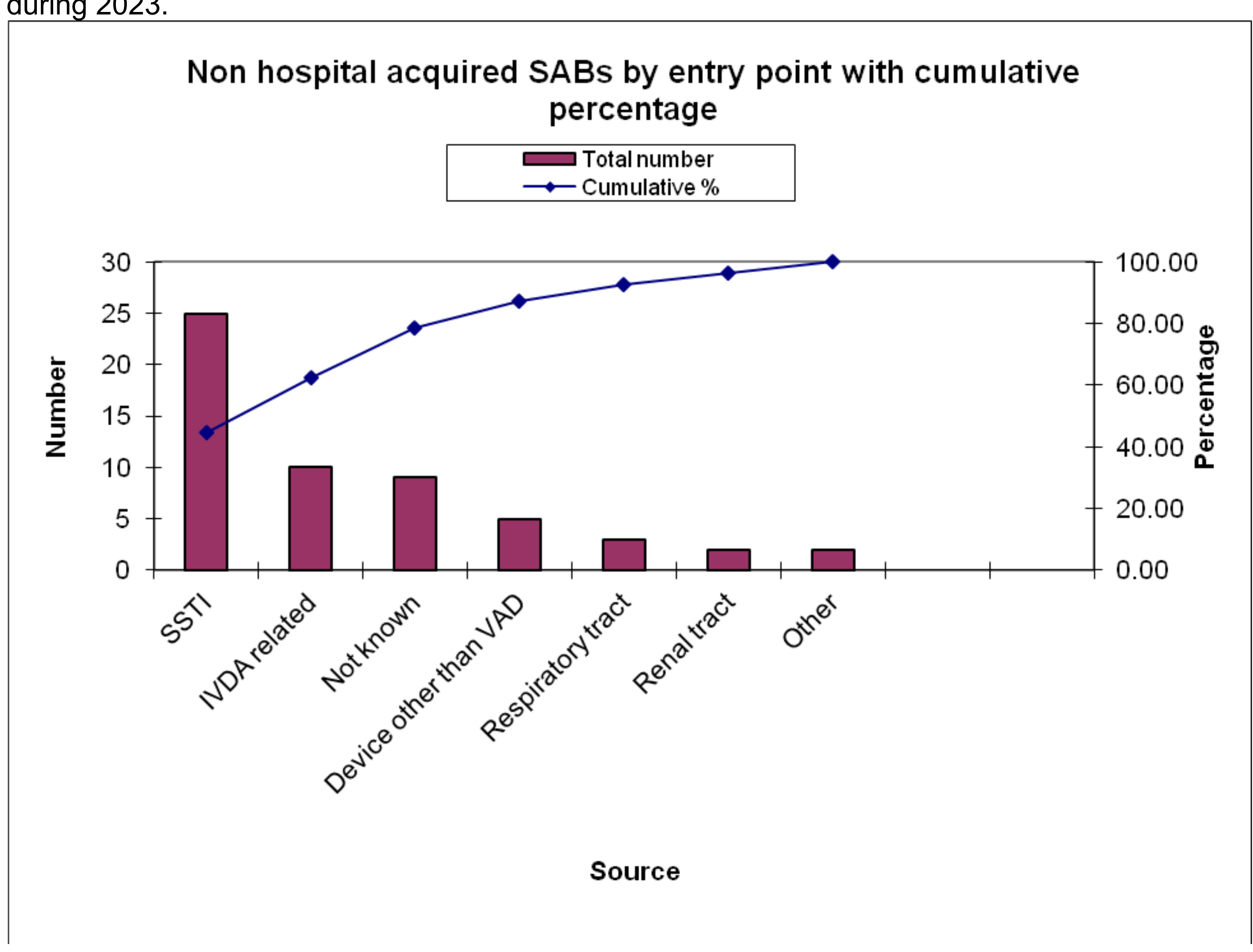


Figure 5: Pareto chart demonstrating the entry point of each non hospital acquired SAB. VAD=vascular access device, Not known=entry point not identified,.

COMMENTS

1. Compared to 2022 there has been a 2.1% decrease in the number of SAB.
2. In 2023 there were two (2.22%) MRSA bacteraemia. **NHS Fife has achieved the local improvement target** set by the ICC for ≤5% of total *S. aureus* bacteraemia to be due to MRSA.
3. The proportion of hospital acquired SAB in 2023 was 37.78% which was slightly more than the 35.9% in 2022
4. The proportion of VADs resulting in a hospital acquired SAB in 2023 was 26.47%. **NHS Fife has achieved the local improvement target** set by the ICC of ≤35% of hospital acquired SAB due to VAD.
5. One SAB was related to a with PVC infection. **NHS Fife has achieved the local improvement target** set by the ICC.
6. When the entry point was identified, skin and soft tissue infections (SSTI) along with IVDA sites were the primary cause of non hospital acquired SAB. The number of non-hospital SAB due to Illicit IV drug increased from 10 in 2022 to 11 in 2023.
7. Figures 2 & 5 indicate the areas where effort needs to be focused to reduce SAB further; Medical devices including vascular access devices, skin & soft tissue infections plus people who inject drugs.
8. SAB where the entry point is not known remain a significant problem and accounted for 15.6% percent of the total in 2023

LOCAL TARGETS SET BY ICC

	Local targets first set in 2014	Review end 2022	Review end 2023
1	Meticillin resistant *S. aurues* to be ≤5% of total *S. aureus* bacteraemia.	No MRSA bacteraemia **Target achieved**	Two MRSA bacteraemia **Target achieved**
2	Vascular access device SAB to be ≤35% of hospital acquired SAB.	18.18% of HAI SAB due to VAD **Target achieved**	26.47 of HAI SAB due to VAD **Target achieved**
3	Total number of PVC related SABs to be halved compared with 2013. (Total in 2013 was 12)	Three PVC related SAB **Target achieved**	One PVC related SAB **Target achieved**

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets were redefined in October 2019 (see DL(2019) 23). All Health Boards have to achieve a 10% reduction in Healthcare associated SAB by 2021/22 using 2018/19 as the base year. This requires NHS Fife to have no more than 66 Healthcare associated SABs by 2021/22. However DL(2023) 06 extended the LDP deadline to 31st March 2023.
NOTE: Healthcare associated SAB referred to in the DL (2019) 23 include hospital acquired SAB plus Healthcare associated SAB discussed defined in this report.

NHS Fife has achieved the SAB reduction LDP target for 2023. Between 1st Apr 2022 and 31st Mar 2023 there were 42 SAB.

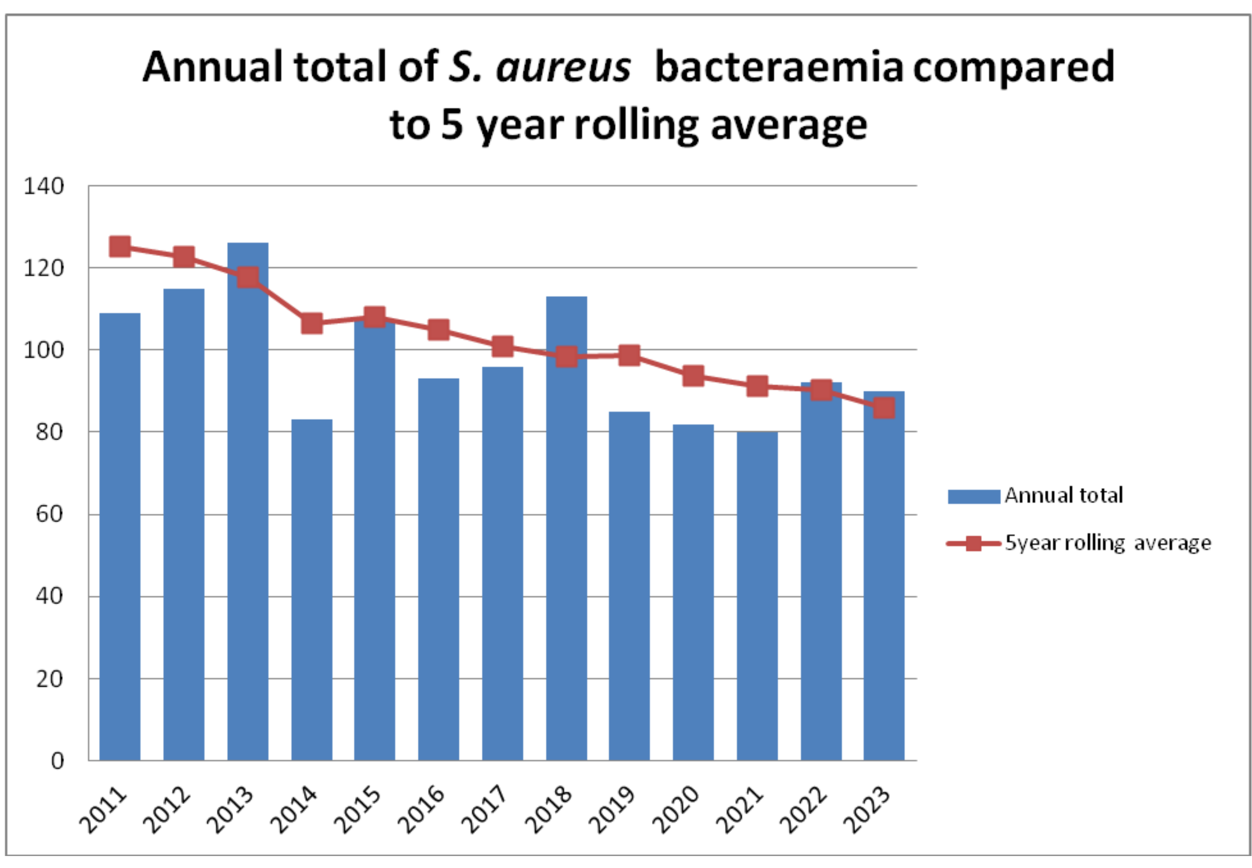
Appendix 1
Entry point for each SAB episode by origin

	Hospital acquired infection (n=34)	34.0	Healthcare associated infection (n=13)	13.0	Community acquired infection (n=43)	43.0	Total SABs by source (n=90)	90.0
Source								
Not known	5	14.7	3	23.1	6	14.0	14	15.6
Vascular access device								
Haemodialysis CVC	8	23.5					8	8.9
PVC	1	2.9					1	1.1
PICC/Midline								
Portacath								
Medical device other than VAD								
Urinary catheter	2	5.9	4	30.8			6	6.7
Ventilation tube	1	2.9					1	1.1
Jejunostomy			1	7.7			1	1.1
SSTI								
Abscess					3	7.0	3	3.3
Skin break	1	2.9	3	23.1	10	23.3	14	15.6
Ulcer					3	7.0	3	3.3
Ezcema	1	2.9					1	1.1
Cellulitis					2	4.7	2	2.2
Pressure sore	1	2.9					1	1.1
Other					4	9.3	4	4.4
Surgical site infection								
Superficial	1	2.9					1	1.1
Deep	4	11.8					4	4.4
Organ or space								
Bone or joint infection								
Miscellaneous								
Renal tract(UTI)	1	2.9	0		2	4.7	3	3.3
Respiratory tract	2	5.9	1	7.7	2	4.7	5	5.6
Related to IV drug abuse	1	2.9			10	23.3	11	12.2
Contaminant	4	11.8					4	4.4
Post procedure			1	7.7			1	1.1
Recurrance	1	2.9					1	1.1
Other	0				1	2.3	1	1.1
Total	34		13		43		90	

Appendix 2
Trend data

Chart 1 demonstrates annual number of *S. aureus* blood stream infections compared to the five year rolling average. Identifies the long term trends set against the spikes and troughs of individual years. Using the 5 year rolling average a subjective judgement can be made on the Health Boards performance in any one year.

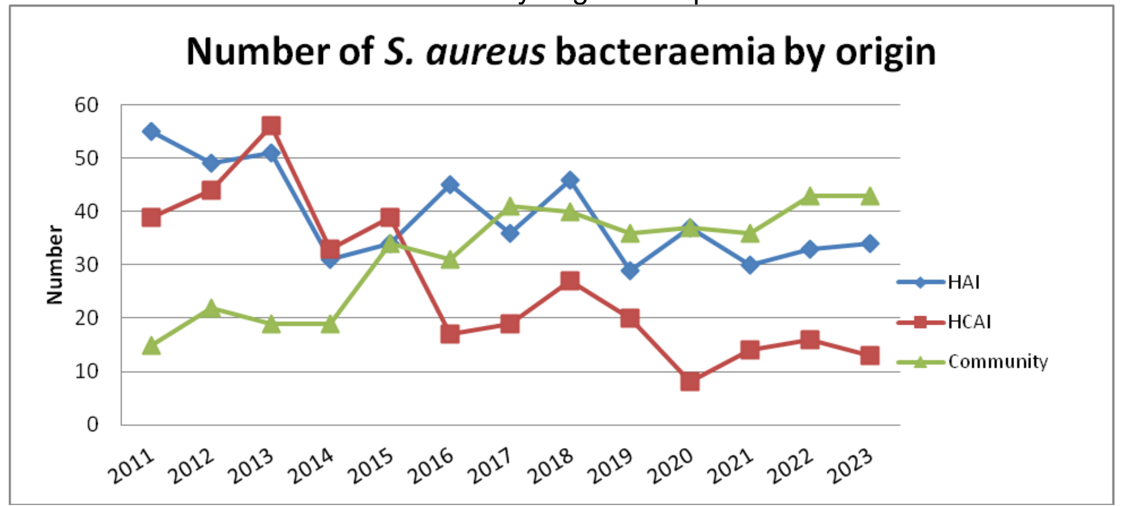
Chart 1: Fife year rolling average of SAB against annual total



Total number of SAB per annum	Performance rating
≥100	Poor
90-99	Average
80-89	Very good
70-79	Excellent

Chart 2 demonstrates the trend in *S. aureus* blood stream infection acquisition by patients and the healthcare sector which requires targeting to reduce the total annual number of *S. aureus* bacteraemia.

Chart 2: Trend in *S. aureus* bacteraemia by origin of acquisition



Appendix 1

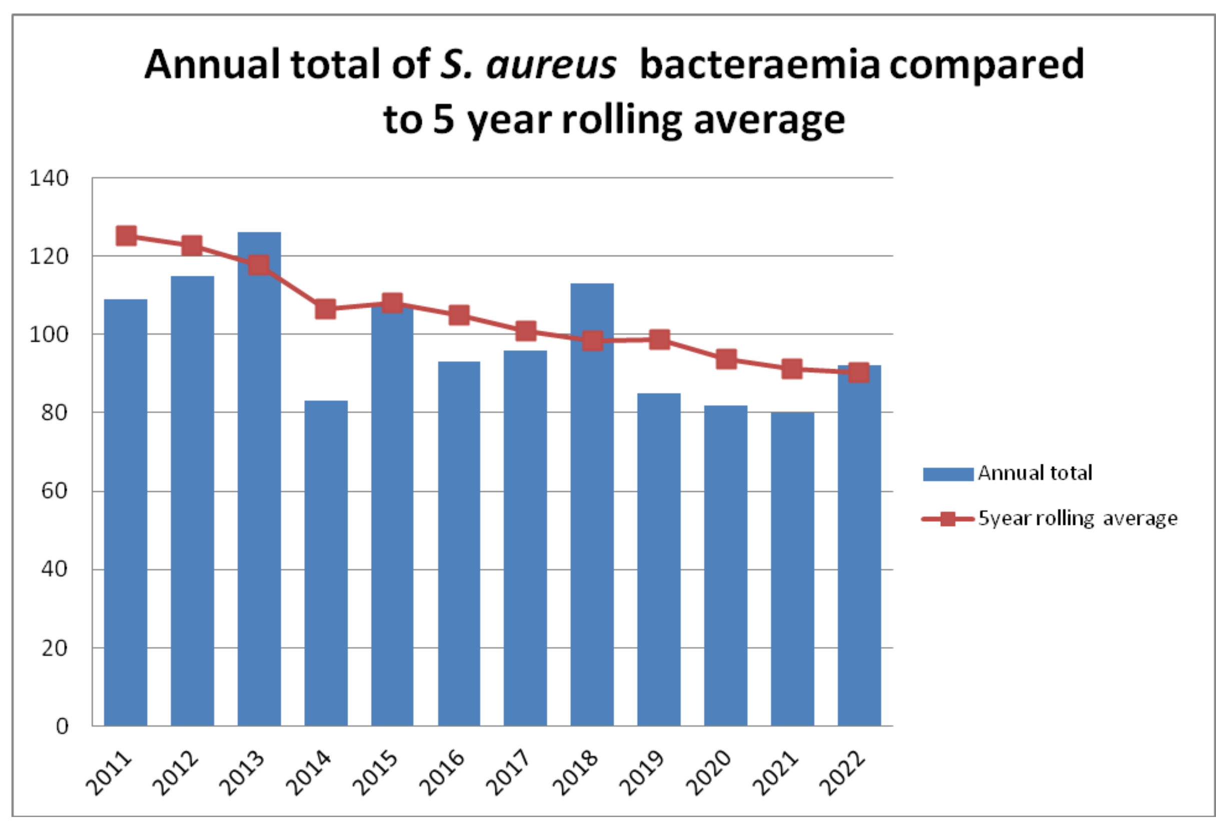
Entry point for each SAB episode by origin

	Hospital acquired infection (n=33)	%	Healthcare associated infection (n=16)	%	Community acquired infection (n=43)	%	Total SABs by source (n=92)	%
Source								
Not known	7	21.2	3	18.8	8	18.6	18	19.6
Vascular access device							0	
Haemodialysis CVC	2	6.1					2	2.2
PVC	3	9.1					3	3.3
PICC/Midline	1	3.0	3	18.8			4	4.3
Portacath			1	6.3			1	1.1
Medical device other than VAD								
Urinary catheter	1	3.0	4	25.0			5	5.4
Nephrostomy	2	6.1					2	2.2
Arthroscopy	1	3.0					1	1.1
SSTI								
Skin break	5	15.2	1	6.3	9	20.9	15	16.3
Ulcer	3	9.1	2	12.5	3	7.0	8	8.7
Eczema					4	9.3	4	4.3
Cellulitis					1	2.3	1	1.1
Other	1	3.0			1	2.3	2	2.2
Surgical site infection								
Superficial					1	2.3	1	1.1
Deep	1	3.0					1	1.1
Organ or space	1	3.0					1	1.1
Bone or joint infection								
Miscellaneous								
Renal tract (UTI)					3	7.0	3	
Respiratory tract	1	3.0			3	7.0	4	4.3
Related to IV drug abuse	1	3.0			10	23.3	11	12.0
Contaminant	2	6.1					2	2.2
Other	1	3.0	1	6.3			2	2.2
Recurrence			1	6.3			1	1.1
Total	33		16		43		92	

Appendix 2
Trend data

Chart 1 demonstrates annual number of *S. aureus* blood stream infections compared to the five year rolling average. Identifies the long term trends set against the spikes and troughs of individual years. Using the 5 year rolling average a subjective judgement can be made on the Health Boards performance in any one year.

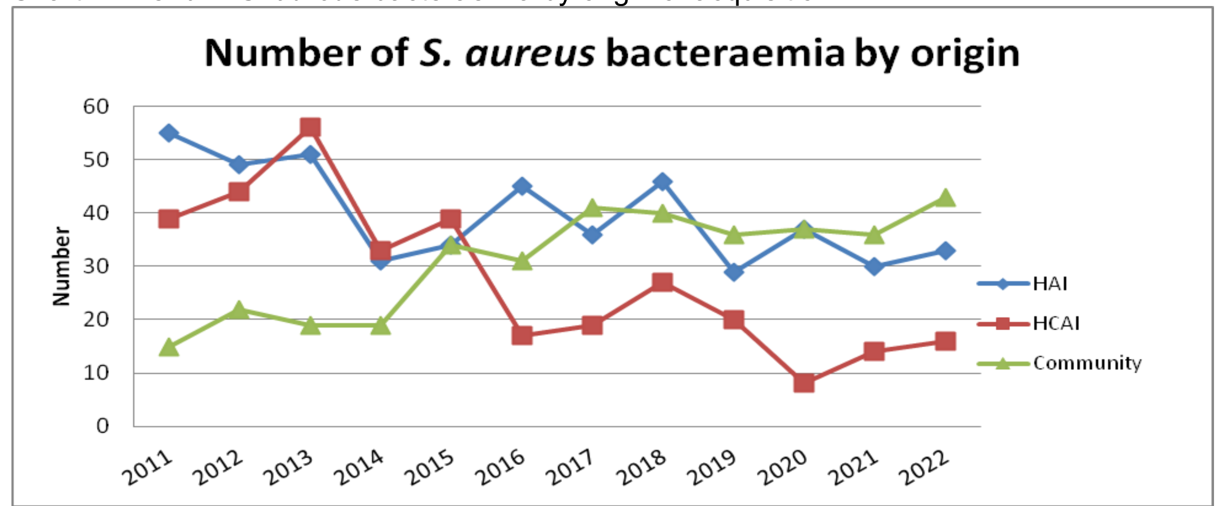
Chart 1: Fife year rolling average of SAB against annual total



Total number of SAB per annum	Performance rating
≥100	Poor
90-99	Average
80-89	Very good
70-79	Excellent

Chart 2 demonstrates the trend in *S. aureus* blood stream infection acquisition by patients and the healthcare sector which requires targeting to reduce the total annual number of *S. aureus* bacteraemia.

Chart 2: Trend in *S. aureus* bacteraemia by origin of acquisition



Appendix 3:
Annual report: *Clostridioides difficile* infection (CDI) in NHS Fife from 1st January 2023 to 31st December 2023

INTRODUCTION

The report demonstrates the *Clostridioides difficile* infection **(**CDI) epidemiology in 2023. The Infection Control Committee is asked to **note** this report and clinical directors and general managers should **act** on the conclusions to further reduce the number of CDI.

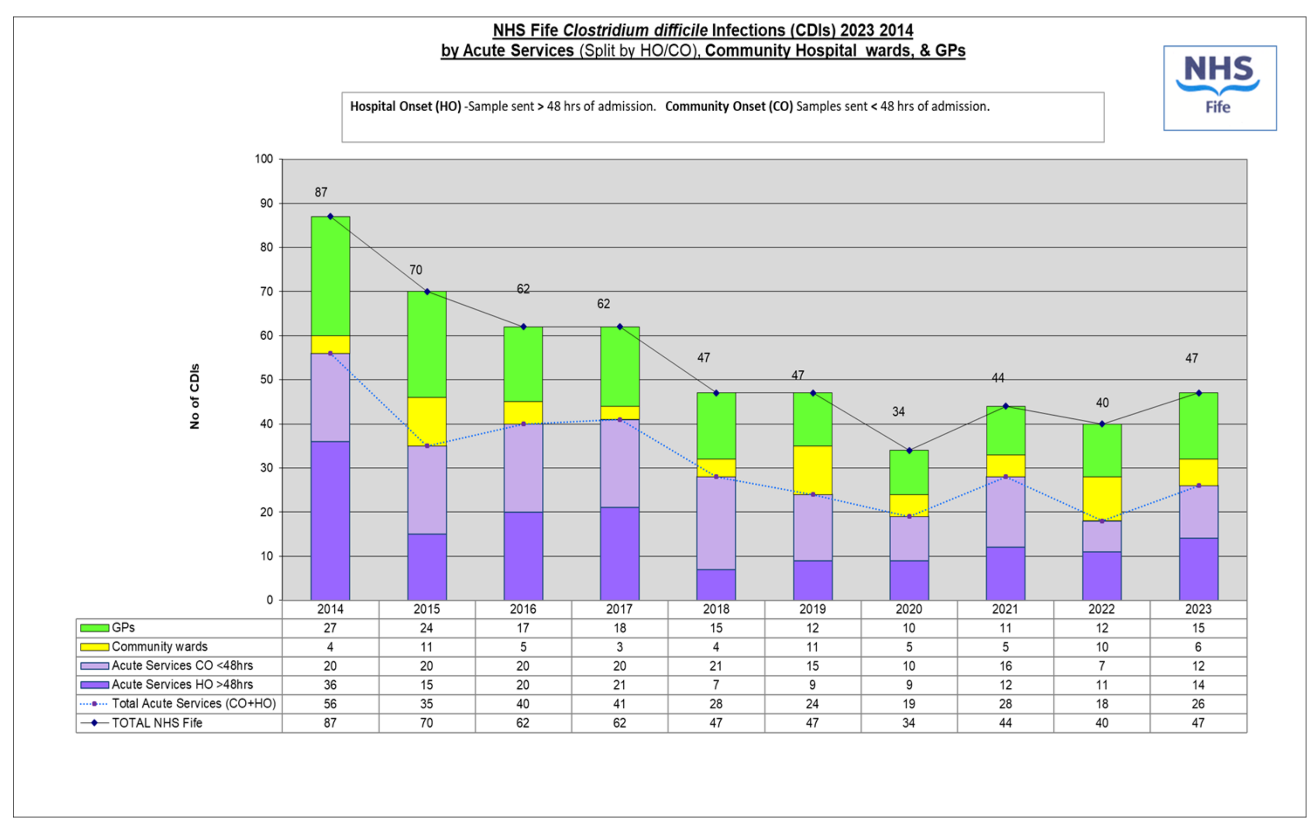
Data for this report has been obtained from surveillance carried out by the IPCT Surveillance and Audit Midwife and Dr Venkatesh. During the surveillance period there was a cumulative total of 47 CDIs.

NHS Fife & Fife Health & Social Care Partnership has seen a steady reduction in the number of CDI cases during the past 10 years (see Figure 1). Much improvement work has taken place to ensure a better outcome for patients and service users. Surveillance focuses on looking at patient risk factors for developing CDI and ensuring appropriate feedback/information is provided to those responsible for the patients care. Antimicrobial stewardship remains an integral part, along with a continued strong focus on infection prevention and control measures.

Each improvement strategy has contributed to the overall reduction since 2014:-

- 46% overall reduction in total number of cases
- 54% reduction in the Acute Services Division (ASD)
- 32% reduction in community wards and GP surgeries

Figure 1: CDI 2014 to 2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
GPs	27	24	17	18	15	12	10	11	12	15
Community wards	4	11	5	3	4	11	5	5	10	6
Acute Services CO <48hrs	20	20	20	20	21	15	10	16	7	12
Acute Services HO >48hrs	36	15	20	21	7	9	9	12	11	14
Total Acute Services (CO+HO)	56	35	40	41	28	24	19	28	18	26
TOTAL NHS Fife	87	70	62	62	47	47	34	44	40	47

RESULTS

Between 1st January and 31st December 2023 there were 47 episodes of CDI in patients aged ≥ 15 years in Fife.
There were 19 hospital associated infection (HAI) CDI, 7 healthcare associated infections (HCAI) and 7 unknowns. Further to this, 14 CDI infections were community associated infections (CAI) (see Figure 2).

Figure 2: CDI cases as associated

2023 CDI cases as associated

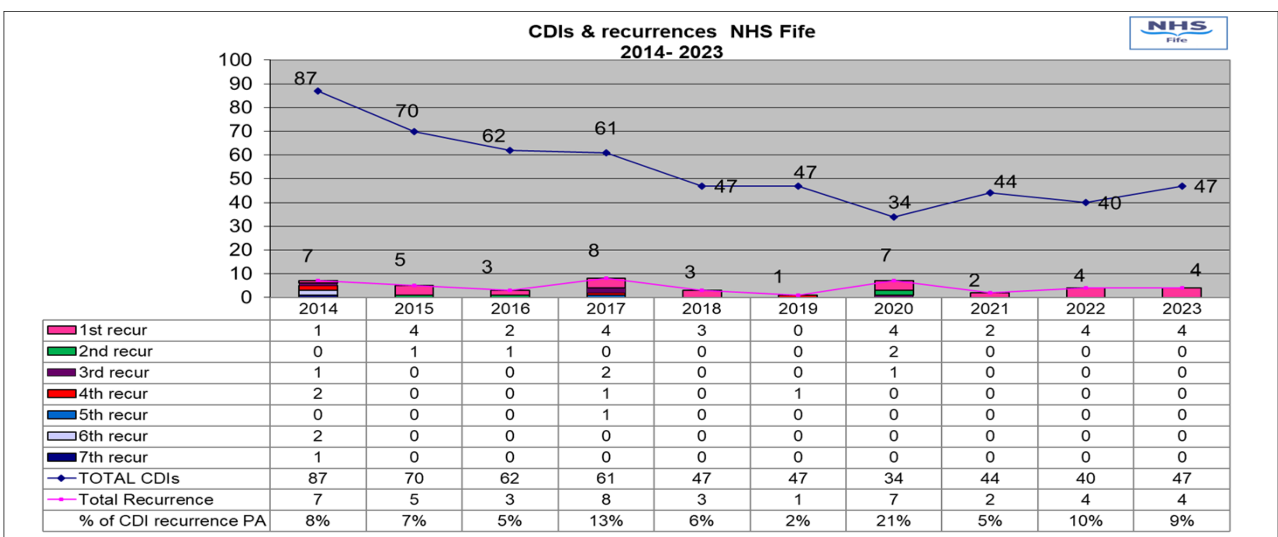
40%
15%
30%
15%

HAI HCAI CAI Unknown

Of the 19 HAI, 14 were associated to the Victoria Hospital and 3 were acquired in Queen Margaret Hospital. Two CDIs were identified in Adamson Hospital.

Of the 47 cases, there were 4 cases which met the ARHAI definition for recurrent CDI (more than 2 weeks and less than eight weeks following the onset of a previous episode) (see Figure 3).

Figure 3: CDI recurrences 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
1st recur	1	4	2	4	3	0	4	2	4	4
2nd recur	0	1	1	0	0	0	2	0	0	0
3rd recur	1	0	0	2	0	0	1	0	0	0
4th recur	2	0	0	1	0	1	0	0	0	0
5th recur	0	0	0	1	0	0	0	0	0	0
6th recur	2	0	0	0	0	0	0	0	0	0
7th recur	1	0	0	0	0	0	0	0	0	0
TOTAL CDIs	87	70	62	61	47	47	34	44	40	47
Total Recurrence	7	5	3	8	3	1	7	2	4	4
% of CDI recurrence PA	8%	7%	5%	13%	6%	2%	21%	5%	10%	9%

BREAKDOWN

19 (40%) of CDI episodes were hospital acquired and 28 (60%) were non hospital acquired. Non hospital CDI can be divided into Healthcare Associated Infection (HCAI), unknown and community acquired infections. Figure 4 Demonstrates the age and gender of patients with a hospital or non hospital acquired CDI.

Figure 4: Age, sex and infection by origin

	Hospital acquired infection* (*n*=19) 40%	Healthcare associated infection* (*n*=7) 15%	Community Acquired infection* (*n*=14) 30%	Unknown (n=7) 15%	Total CDI (*n*=44)
	n (%)	n (%)	n (%)	n (%)	n (%)
Male	10 (53%)	6 (86%)	5(36%)	3 (43%)	24 (51%)
Female	9 (47%)	1 (14%)	9 (64%)	4 (57%)	23 (49%)
Age: mean (Range) years	69 (31-95)	70 (57-82)	73 (48-89)	71 (56-86)	72 (31-95)
Single infection	18 (95%)	7 (100%)	12 (86%)	6(86%)	43 (91.5%)
Recurrent infection	1 (5%)	0 (0%)	2 (14%)	1 (14%)	4 (8.5%)

***The origin of a CDI is defined in the Protocol for the Scottish Surveillance Programme for Clostridium difficile Infection. User Manual**

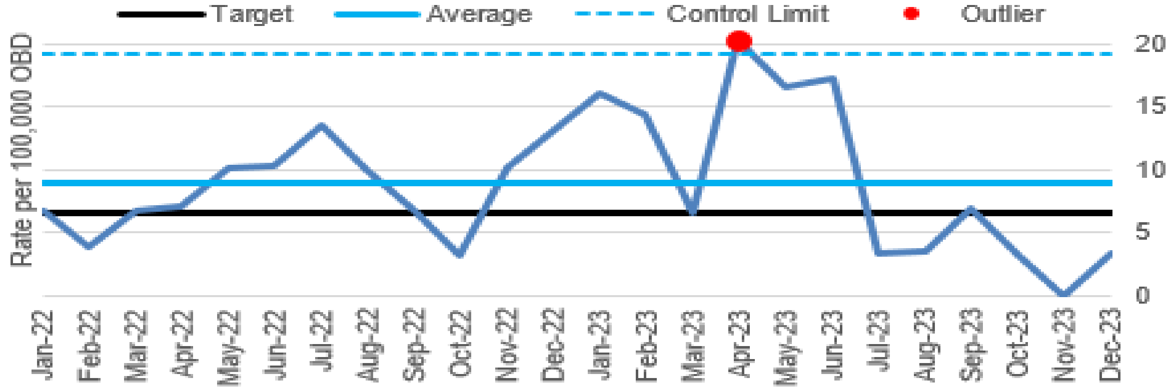
2017, Version 4.

NATIONAL LOCAL DELIVERY PLAN (LDP) TARGETS

The National LDP targets set for the end of the financial year 2023/4 required all Health Boards have to achieve a 10% reduction in Healthcare associated CDIs (using 2018/19 as the base year). This requires NHS Fife to have no more than 23 Healthcare associated CDIs by 2023/24. Unfortunately, it looks unlikely that NHS Fife will meet that target.
NOTE: Healthcare associated CDI referred to in the DL (2019) 23 include hospital acquired CDI **plus** healthcare associated CDI **plus** unknown CDIs as defined in this report.

Figure 5 demonstrates how each month compares to the target. It is evident that the rate varies significantly from month to month,, sometimes below and other times well above the target.

Figure 5 – NHS Fife 2023 CDI monthly rate against the Improvement Trajectory



Each Fife CDI case is reviewed to ascertain risk factors for developing the infection. Figure 6 displays a breakdown of risk factors for HAI, HCAI, Unknown and CAI.

The highest risk factor is antibiotic therapy with 85 % of total cases having received an antibiotic(s) within 12 weeks prior to the CDI positive result.

The second highest risk factor, associated with 68% of total cases, was Proton Pump Inhibitors (PPI), followed by immunosupression (21%), gastric history (11%) and lastly recurrent infections (9%).

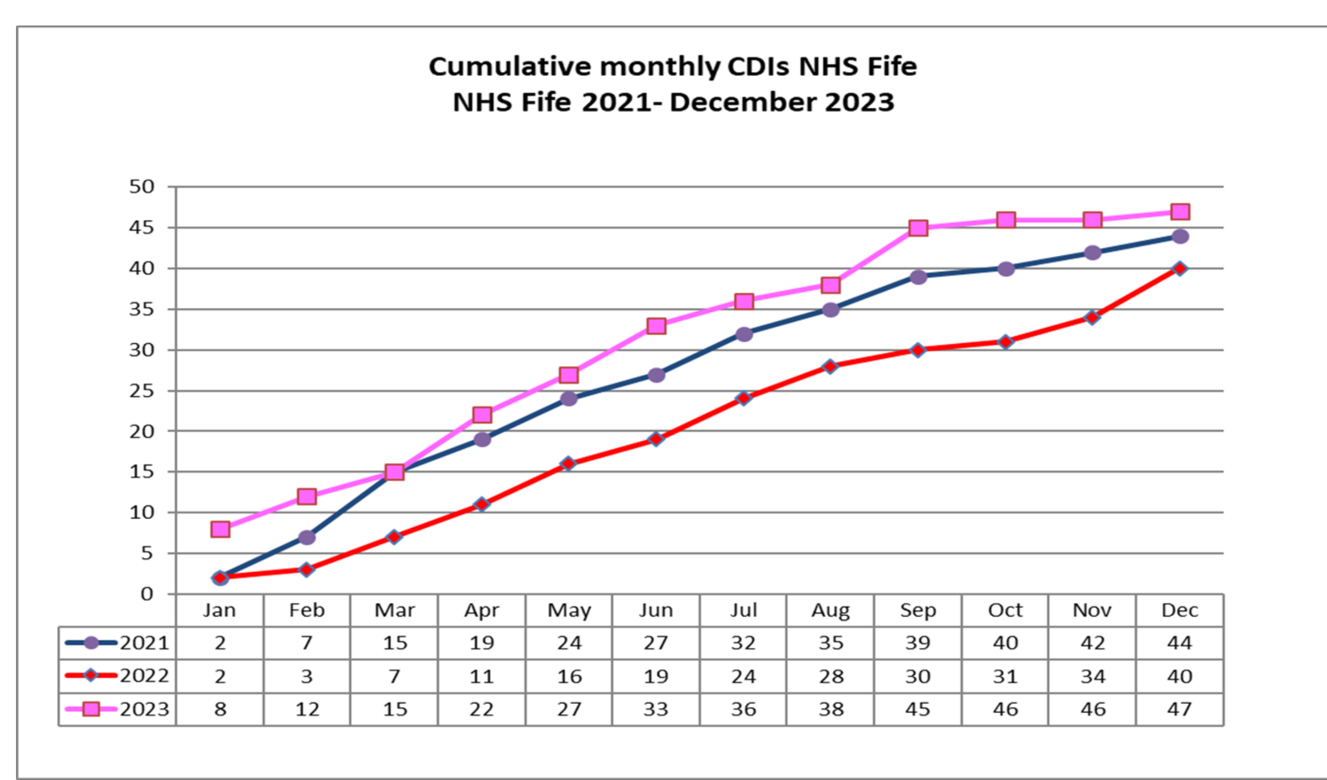
Figure 6 – CDI risk factors

	HAI (n=19)	%	HCAI (n=7)	%	Unknown (n=7)	%	CAI (n=14)	%	Total number 47	%
Antibiotic	18	95	7	100	6	86	9	64	40	85
Gastric history	3	16	0	0	1	14	1	7	5	11
Immuno supression	4	21	1	14	2	29	3	21	10	21
PPI	16	84	6	86	4	57	6	43	32	68
Recurrence	1	5	0	0	1	14	2	14	4	9

Trend data

Figure 7 demonstrates the annual number of *CDIs* compared to the previous 2 years. It shows that 2023 had a higher number of cases than during 2022 and 2021.

Figure 7



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	2	7	15	19	24	27	32	35	39	40	42	44
2022	2	3	7	11	16	19	24	28	30	31	34	40
2023	8	12	15	22	27	33	36	38	45	46	46	47

Figure 8 demonstrates the number of Healthcare Associated Infections (HAI+HCAI+Unknown) during 2023 compared to the previous 2 years. It shows that the number of cases has increased over the past couple of years.

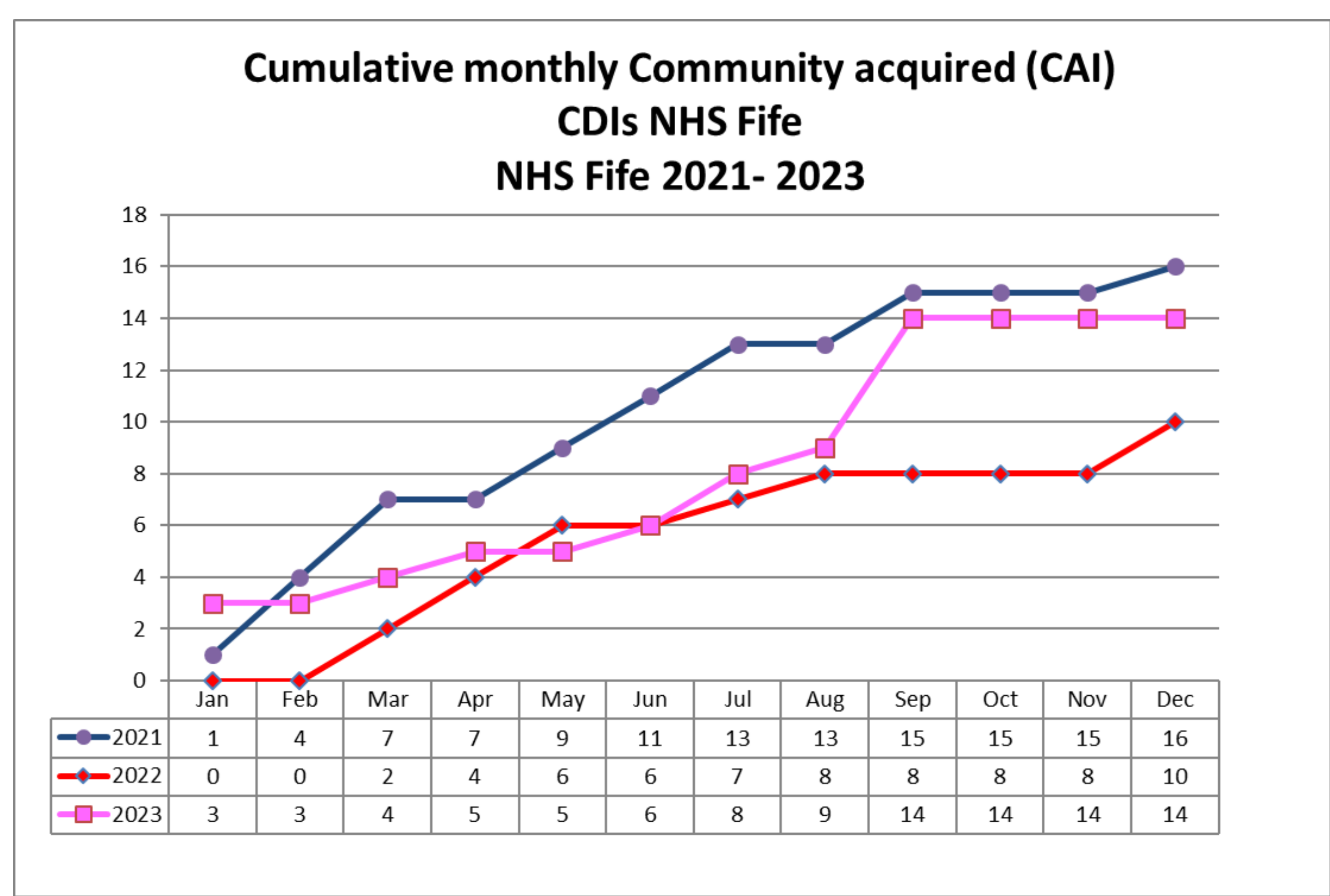
Figure 8 – CDI cumulative graph for 2021-2023 for all HCAIs (HAI+HCAI+Unknown)

Cumulative monthly Healthcare associated (HAI +HCAI+Unknown) CDIs NHS Fife
NHS Fife 2021- December 2023

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	1	3	8	12	15	16	19	22	24	25	27	28
2022	2	3	5	7	10	13	17	20	22	23	26	30
2023	5	9	11	17	22	27	28	29	31	32	32	33

Figure 9 displays the number of CAI infections, in comparison to the previous 2 years, and shows that the number of infections was higher than during the previous year, but lower than in 2021.

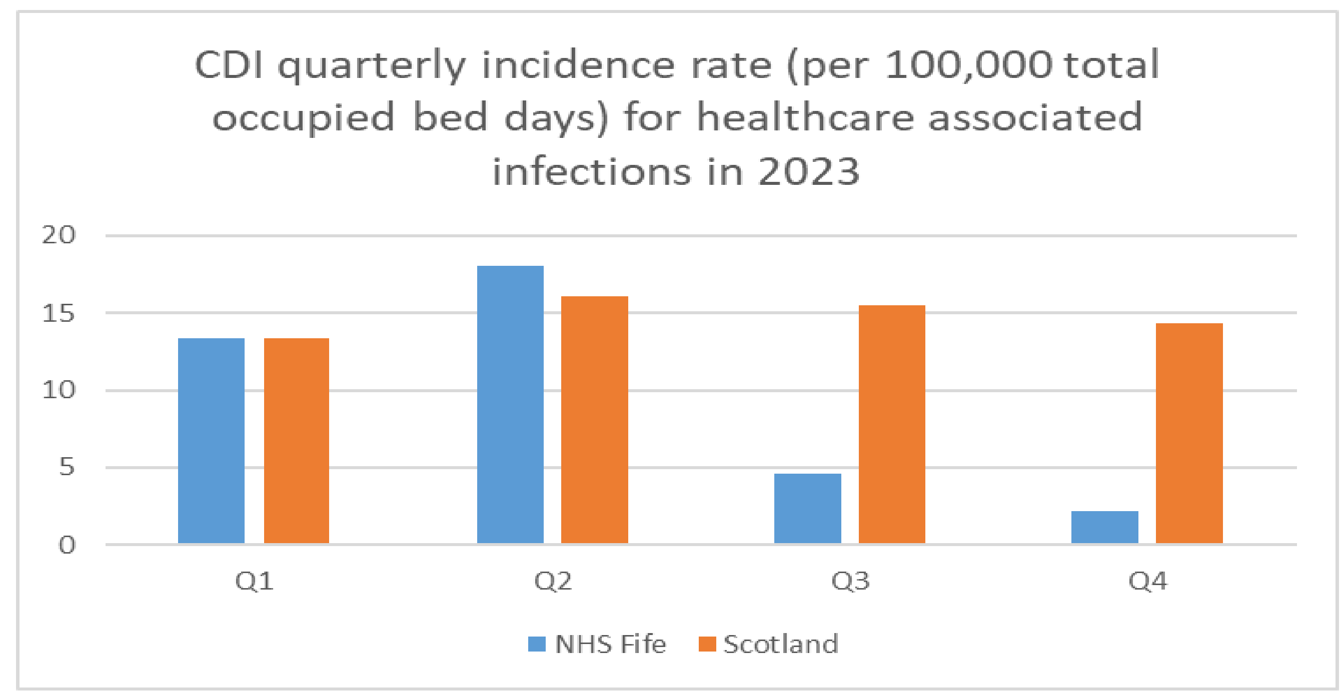
Figure 9 – CDI cumulative graph for 2021-2023 for all CAIs



National context

At present, there is no national comparison for overall year analysis as the ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) 2023 Annual Report has yet to be published. However, according to Figure 10, NHS was above the national comparator for Q2 2023, but was well below it during Q3 and Q4 2023..

Figure 10 – National comparison of Fife CDI quarterly incidence rates in healthcare associated infection cases during 2023



COMMENTS

5. Compared to 2022, there has been a 14.8% increase in the total number of CDIs
6. The proportion of hospital acquired CDI in 2023 was 40%
7. 95% HAI cases had previous (in the 12 weeks prior to CDI) antibiotic use as a risk factor for CDI
8. In 2023 there were 4 recurrences in CDI and 5 cases of previous infection

Challenges identified in 2023
Upward trend in CDI positive cases in the latter part of 2023.

Management of recurrence of CDI for 2023
NHS Fife continue to use pulsed Fidaxomicin for CDI cases that are at high-risk of recurrence.
Bezlotoxumab is now unavailable and exploring availability of commercial FMT as an alternative modality for managing recurrences alongside usual standard of care.

Key areas to be addressed to achieve the HCAI CDI 10% reduction target by 2024
Focus on Antimicrobial Stewardship and AMR practices
Aim to consistently reinforce AMR in Board induction and teaching for GP trainees.
Reiterate AMR best practice when clinicians call microbiology for advice and when CDI positive results are discussed with clinicians.
Dissemination of surveillance data through newsletters to raise awareness to GPs of CDI rates and importance of prudent antimicrobial prescribing.
Close monitoring and robust surveillance of cases in the community and acute healthcare settings.

AREA MEDICAL COMMITTEE (Meeting on 13 August 2024)
No issues were raised for escalation to the Clinical Governance Committee.

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON TUESDAY 13 AUGUST 2024 VIA MS TEAMS

Present:

Dr Chris McKenna (Chair)	Medical Director
Dr Susie Mitchell (Chair)	Fife LMC Chair
Dr Fiona Henderson	Fife LMC Honorary Secretary
Dr Glyn McCrickard	Fife LMC Representative (from 3.20pm)
Dr Helen Hellewell	Deputy Medical Director H&SCP
Dr Ian Fairbairn	CD, Medical Directorate
Dr Iain MacLeod	Deputy Medical Director ASD
Dr Jackie Drummond	Interim CD, Complex & Critical Care H&SCP
Dr Sally McCormack	AMD, Medical & Surgical Directorate (from 3.40pm)
Dr Shirley-Anne Savage	Associate Director for Risk & Professional Standards
Dr Kim Steel (on behalf of Prof Morwenna Wood)	Associate Director of Medical Education

In Attendance:

Catriona Dziech (Notes)	Executive Assistant to Medical Director

1 APOLOGIES FOR ABSENCE

Apologies were received from Dr Caroline Bates, Dr Claire MacIntosh, Dr John Morrice, Dr Joy Tomlinson, Prof Morwenna Wood, Dr Robert Thompson

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 11 JUNE 2024

The notes of the meeting held on 11 June 2024 were approved as an accurate record of the meeting.

4 MATTERS ARISING

i) Stand Up Secondary Care Medical Staff Committee

Chris McKenna and Iain MacLeod have been unable to discuss to date but will endeavour to do so before the next meeting.

ii) Amendments to Constitution / Terms of Reference (ToR)

The Constitution has been amended to a Terms of Reference with the addition of Shirley-Anne Savage to the Membership in her role as Associate Director for Risk & Professional Standards.

The following further amendments would be made to the ToR;

- Changing Helen Hellewell and Iain MacLeod's job titles to reflect their new role
- Remove the Representative from Addictions

- Remove representative from Urgent Care Services Fife as representation would now be through the Clinical Director. Helen Hellewell will arrange to invite the new Clinical Director in Primary & Preventative Care to attend future meetings.

Action: HH

Following discussion, it was noted that the current membership of the Committee was historical and to ensure there is equity across the membership Chris McKenna, Susie Mitchell and Shirley-Anne Savage would consider this further outwith the meeting. A revised Terms of Reference will be brought back to the Committee for consideration and final sign off.

Action: CMcK/SM/SAS

iii) Invite Claire Fulton to give update on Adverse Events

Claire Fulton will attend the meeting on 08 October 2024 to provide an update.

iv) Invite Ben Hannan to give update on RTP

Ben Hannan will attend the meeting on 08 October 2024 to provide an update.

v) Comms for redirection of Primary Care Patients to ED

There was a discussion around the recommendation to redirect patients from Primary Care to ED and whether we should be proactive and issue communication to secondary care.

Helen Hellewell advised there has been discussion at the Primary Care Leads meeting and currently other Boards have not issued any patient facing comms.

It was suggested the communication could be part of the notes of this meeting which is circulated to colleagues in secondary care.

In closing Chris McKenna said that this was more about expressing the low-grade consistent burden of pressure that exists within Primary Care and finding an appropriate form of communication to deliver the message to Secondary Care that highlights this is a recommendation from the BMA and it may need to be enacted from time to time when practices are under pressure. Chris McKenna and Helen Hellewell agreed to consider this further and prepare a form of words for circulation to Secondary Care.

Action: CMcK/HH

5 STANDING ITEMS

i) Financial Position – Including *(IPQR taken to the Board on 30 July 2024)*

Chris McKenna advised despite all the hard work, RTP remains challenging. The savings around RTP are being tracked. However, spending is still more than what has been allocated and attempts to try and address this will continue.

Maxine Michie to be invited to attend a future meeting to provide a detailed update.

Action: CMcK

ii) Adverse Events Update

Chris McKenna advised that Gemma Couser and Claire Fulton will be arranging a leadership event providing an update for all Clinical Leads and Clinical Directors.

Chris McKenna said he also intends to do something separately towards the end of the year with his own reflection in relation to adverse events.

The flash report usually included on the agenda will be circulated separately.

Action: CDz

iii) Medical Staff Committee

Chris McKenna and Iain Macleod to consider.

iv) Update from GP Sub Committee

Fiona Henderson advised that there were no significant updates at this time.

Chris McKenna advised that he would be raising an issue at the next GPSC meeting in relation to IRMER and would also be writing to all GPs clarifying the IRMER Regulations and Policy as set out by the UK Government.

v) Realistic Medicine

No update.

vi) Medical Workforce

Chris McKenna advised recruitment within adult mental health is currently the biggest challenge faced, and he agreed to work with Jackie Drummond and Helen Hellewell to support the team with a medium / long term plan going forward. Updates will be brought back to the Committee in due course.

Susie Mitchell advised that a maternity locum had been recruited. However, as they are currently working as a locum in both NHS Lothian and Fife eHealth in NHS Fife have been unable to provide them with a separate NHS Fife email address as well as a Lothian address. Chris

McKenna asked Susie Mitchell to email him the details and he will arrange to sort this out with eHealth.

Action SM/CMcK

Jackie Drummond advised that GMC sponsorship has been approved for the Cesr Fellowship. Jackie Drummond advised that Aberdeen received 200 applications per host so it would be good for us to achieve something similar. A meeting is required between HR and the Service Managers around the logistics for people who may need help with visas and accommodation etc. Chris McKenna said this was positive news and suggested that Jackie Drummond gain support from Shirley-Anne Savage in her role as head of Professional Standards. Helen Hellewell suggested linking in with Kim Steel to ensure the doctors have good rapid support, in the same way as Gateway doctors do.

Iain MacLeod advised for the first time ever that less than 50% of Job Plans were in discussion indicating that more have been signed off than not. This is massive progress within the year with substantive work from all the Clinical Directors, AMDs etc.

It was noted there has also been recruitment to Radiology.

vii) Education & Training

Kim Steel advised that there were more senior trainees than previously. In terms of Acute there are ST5 and ST6s which make a massive difference to the training and mentorship of the other doctors on the wards. The new starts from August are 47 FY1s, and 9 Gateways, 40 FY2s, 37 GPSTs (for 44 slots). This leaves 7 unfilled GPST slots despite full recruitment this year. There are also 82 STs, 7ACCSs (20 of these are IMGs with four brand new to UK practice).

The National Training Survey results are being considered for comment. There are three specialties in the bottom 2%, one of which is Psychiatry. It was anticipated this would be included despite the huge amount of work that was undertaken around the recent visit. Medicine and Surgery are also included so thought needs to be given on how to plan for improvement.

During the Summer holiday, 41 Fife school children have visited the site and been shown round to encourage and inspire them to be the medics of the future.

77% of GP practices are involved in training. 23 involved with postgraduate trainees with a large number involved in undergraduate.

New Chief Registrars have been appointed in General Medicine, General Surgery, Urology and Obs & Gynae. Dr McKenna said he was hoping to align diaries to engage with them. Kim Steel said we do try to recruit senior

people, although this means some specialties that have more junior trainees miss out such as Psychiatry where there has not been a GPSTCR for several years with no applicants. An increase was seen in the number who brought forward QI projects due to actively getting them involved. Psychiatry has their own lead registrar, chief registrar so we need to ensure we engage with these specialists especially within the Partnership to ensure the trainees can link in.

Action: CMcK

Chris McKenna advised we are in the process of setting up a Partnership Board with the University of St Andrews in relation to NHS Fife becoming a university hospital teaching Board. Terms of Reference will be agreed with the University and Subgroups will sit under the Partnership Board to support ongoing partnership work across the four domains; People, Social Sustainability, Research Development & Innovation and Education.

viii) Update from Division of Psychiatry

Jackie Drummond advised that a lot of work is underway around the Mental Welfare Commission action plan to make it more meaningful for the service.

Work is also being undertaken around the Strang Report, which covered the independent review of services in Tayside. Meetings have been held to establish where we are in terms of benchmarking ourselves against the recommendations and how to progress. As part of this there has also been helpful discussion around identification, management, and ownership of clinical risk.

There are continuing challenges around demand of new development disorders with a huge increase in the number of referrals. It has been agreed to meet to try and develop a shared care agreement to ease the friction this can cause in the system. There has been good engagement with Primary Care colleagues in managing the various issues which arise.

Workforce currently remains the biggest single difficulty in the context of National difficulties as there is not a flow of people coming through to consultant posts. There is a 102-point action plan. But this is challenging to implement at the moment due to the leadership structure within Mental Health. Hopefully with the appointment of an AMD there will be scope to progress this further.

Chris McKenna advised that a strategic Mental Health Oversight Group has been established which will give more focus to dealing with the current issues. This is also important given that the capital project for mental health has been paused indefinitely.

Chris McKenna reported that there are National concerns around the approach to forensics and a meeting has been arranged with the Scottish Government to highlight concerns and discuss further.

6 STRATEGIC ITEMS

i) GMS Implementation

Chris McKenna and Susie Mitchell agreed to meet and discuss the Terms of Reference and the agenda going forward and if this item should remain on the agenda.

Action: CMcK/SM

ii) RTP Update

There will be a formal update at the next meeting in October. It was agreed to share with the Committee the slides Ben Hannan presented at the recent Private Session of the Board.

Action: CMcK

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee: 21 May 2024

Noted.

ii) Notes of the Clinical Governance Oversight Group: 18 June 2024

Noted.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 19 June 2024**

Noted.

8 AOCB

There was no other competent business.

9 DATE OF NEXT MEETING

08 October 2024 at 2pm via MS Teams

CANCER GOVERNANCE & STRATEGY GROUP

(Meeting on 14 August 2024)

No issues were raised for escalation to the Clinical Governance Committee.

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 09:00 on Wednesday 14th August 2024 via Microsoft Teams

Present:	**Designation:**
David Astill (DA)	Patient Representative
Izzy Corbin (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Susan Fraser (SF)	Associate Director of Planning & Performance
Nick Haldane (NH)	Lead Cancer GP
Janette Keenan (JK)	Director of Nursing
Murdina MacDonald (MM)	Lead Cancer Nurse
Chris McKenna (CM) Chair	Medical Director
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Shirley-Anne Savage (SAS)	Associate Director for Risk and Professional Standards
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Nicky Connor (NC)	Interim Director Health and Social Care
Alistair Graham (AG)	Associate Director Digital and Information
Rishma Maini (RM)	Consultant - Public Health
Linda McGourty (LMcG)	GP
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Kathy Nicoll (KN)	Cancer Transformation Manager
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
John Robertson (JR)	Lead Cancer Clinician - Surgery
Nicola Robertson (NR)	Director of Nursing, Corporate
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Fiona Towns (FT)	Patient Representative
Amanda Wong (AW)	Associate Director of Allied Health Professions
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Andreas Luhmann (AL)	Consultant – General and Upper GI Surgeon

		Action
	Welcome	
	CM welcomed everyone to the meeting.	
1.	**Apologies for absence**	
	Apologies for absence were **noted** from the above named members.	
2.	**Unconfirmed Note of the previous NHS Fife Cancer Governance & Strategy Group Meeting of 30 May 2024 via Microsoft Teams**	
	The Unconfirmed Note of 30 May 2024 was **accepted** as an accurate record.	
3.	**Action Log**	

		Action
	300524#1 – This action to be closed as it will be taken under the operational group.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	CD noted that their focus for some months has been around RTP. CD advised they have been active around cancer, and they have had the opportunity to bid for some money against a 30 million pound pot for the Scottish Government and have been successful in that. CD noted they also made a bid around cancer pathways, particularly around lung and head and neck. They are currently waiting on feedback in relation to those. CD advised the group has not been active but is aiming to get the group back together in September.	
4.2	**Cancer Risks**	
	Papers were shared with the group on cancer risks. CD noted there was nothing to escalated in terms of operational risks. SAS noted that since the last report to the group, the overall number of agreed risks on the Cancer Risk Register has decreased from 12 to 11. SAS advised in summary: • **Closed Risks:** 1 risk has been closed. – 393 – ENDOSCOPY CAPACITY • **New Risks:** No risks to delivery of the Cancer Framework have been opened in Datix. **Risk Level breakdown:** 3 High and 8 Moderate **Risk Rating and Level:** Unchanged from the previous report **Risk Target:** No risk has achieved its target. The following Cancer Framework risks have been updated: • 2895 Cancer Workforce • 2898 D&I Challenges • 2897 Financial Delivery • 2896 Property and Infrastructure	
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Report**	
	SAS advised that this document provides an update on year 1 and year 2 and the progress made against the 8 commitments agreed in the Cancer Framework.	

		Action
	The report shows good progress has been made each year with some very good work carried out to improve cancer services and patients' experience. SAS asked if the group are happy to sign off the update so that this can be widely circulated across the organisation. It was noted that the actions for 2024-25 are currently being drafted. CM asked what to we do with this paper next as it is an important paper. SAS advised they will take it to the Clinical Governance Committee through EDG. CM noted he is happy for that to happen. This is to be taken to the November committee meeting as there is no room on the agenda for the September meeting. CM advised the group to look through the document and to get in touch with SAS if anyone has any comments.	
5.2	**Projects Update**	
5.2.1	**Community Pharmacy**	
	This item will be carried forward to the next meeting.	
5.2.2	**Rapid Cancer Diagnostic Service (RCDS)**	
	MM went through the project status report with the group. MM noted the key points are: • Evaluation report for the Colorectal pathway is being developed and will be shared when complete. • Lifestyle Medicine evaluation being developed and will be shared when complete. MM noted the key risk is: • Funding (note Pilot extended to March 2025). Scottish Government has provided additional funding until March 2025. CM advised if you look at the referrals, they are pretty equal across all 5 areas, however, when you look at the pickup, the pickup is greater in SIMD1 and SIMD2. CM advised he wonders whether we have any data that goes further than that. MM to look into this and see if this data can be pulled together. CM asked of those patients who had a non-cancer diagnosis or no diagnosis, at 1 year where there any patients in that group that subsequently got diagnosed with cancer. MM to look specifically at year 1 and will look at where we are now to see if we have any cancer diagnosis. MM to link in with FQ regarding looking at this data.	**MM** **MM** **MM**

		Action
	CM asked if we are ever to going to publish any of this data. MM advised they can look to publish it. CM advised it is powerful data and they can link in with the university to think about getting this published. CM noted it is a very powerful and effective pathway. CM advised it is very successful and they would seek to continue to support this.	
5.2.3	**Rapid Access Diagnostic Clinic (RADC) Update**	
	MM went through the SBAR with the group. RADC commenced on 15th August 2023; the clinic has now seen 313 patients. MM provided an update: • The RADC team are meeting monthly with the PI of the project who has left her post with NHS Fife but has been given an Honorary Contract, to allow her to continue as PI of the project. • The RADC clinic sessions are one morning (Thursday) per week, the nurse running the clinic is studying until August 2024, when the clinic sessions will increase to two per week. • Regular meetings are being held with Researcher from Stirling University. • The Researcher from Stirling University has continued to interview staff and patients as part of the evaluation of the project. 12 staff interviews with 11 people and 10 patient interviews have taken place. • Patient Navigators are continuing to contact patients from the RADC: prostate pathway for permission to share the patient survey link or offer a survey telephone call from the University if preferred. 161 patients have now completed the patient survey, which closed at the end of July. • PM is continuing to assist the nurses and navigators in the Urology Cancer Team with project support for a new information session for patients considering a prostatectomy procedure, as part of their treatment pathway. The first session was held this month, and the patient feedback was excellent with additional information suggested by the patients being included in the sessions going forward. • PM is providing project support to the Endoscopy Clinical Educator in a service improvement test of change. • PM is meeting the NHS Finance assistant monthly to ensure the project is meeting the financial requirements of Cancer Research UK. DA advised that he noticed that there are information sessions to advise patients at the beginning of their journey regarding prostatectomies. DA asked has any thought been given as to involving former patients who have actually gone through that to find out how it was for them. MM	

		Action
	advised that Audrey, their CNS who leads on the information sessions, has just set that test of change up and it is evolving. MM will link in DA with Audrey. CM asked if there were any plans to provide some data and outcomes for the patients that go through this pathway. MM noted they shared the data on the first 100 patients that went through at the last meeting. MM advised they are waiting on the Stirling University evaluation. CD advised they will be looking at using their cancer waiting times money against that as this pathway has been so beneficial for patients. CD advised in terms of how they use their consultant resources as well, CD has been meeting regularly with the principal investigator with the university and they are looking at how they can secure that. CD noted that as we have now started this, it is not something we can step away from.	
5.2.4	**Single Point of Contact Hub (SPOCH) Evaluation**	
	SAS noted they have completed the second part of the SPOCH Evaluation, so they have a full year update. SAS advised SPOCH continues to be successful and highlighted just some of the successes: • 92% of calls are resolved by SPOCH. • There has been a reduction in incoming calls to CNSs. • Merge of SPOCH and the Central Referral Unit to ensure business continuity for both the management of the urgent suspected cancer referrals and patient support on their pathways. • Management of the negative qFIT pathway which provides a wraparound service from supply of a test to advising of negative results for symptomatic patients. • Initiation of the lung cancer pathway supports patients who have an abnormal chest x-ray through to relaying a negative results to reassure the patient in a timely manner.	
6.	**FUNDING**	
6.1	**Funding Update**	
	SAS provided an update to the group and advised of the following funding allocation for 2024-25: • CWT Funding (recurring) - £776,00 • CWT Funding (non-recurring) - £474,524 • AO/SACT (recurring) - £317,565 • RCDS/RCDS Expansion (non-recurring) - £399,581 • SPOCH (recurring) - £107,354 • CRUK TET funding to support Prostate Pathway (non-recurring) - £213,00 • Detect Cancer Early – Optimal Pathways - TBC • Macmillan Project Manager (non-recurring) - £60,481	

		Action
	SAS provided an overview of the funding: • CWT recurring funding is supporting substantive posts. • CWT non-recurring funding is supporting treatment and backlog. • AO/SACT recurring funding is supporting substantive posts. • RCDS non-recurring funding has been extended until March 25. • DCE funding has been allocated and bids have been put forward. Await decision. • We are unable to appoint to the Macmillan Project Manager post therefore funding will be returned.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q1 2024**	
	CD went through the paper that was shared with the group. The **62 Day Standard** states that 95% of patients urgently referred with a suspicion of cancer will wait a maximum of 62 days from referral to first cancer treatment: • In Scotland there were **4294** eligible referrals within the 62-day standard, a decrease of **3.6%** on the previous quarter but an increase of **15.3%** compared with quarter ending 31 December 2019. • **70.4%** of patients started treatment within the 62-day standard compared with **71.1**% in the previous quarter and **83.7%** for quarter ending 31 December 2019. • The 62-day standard was not met by any NHS Board. • Half the patients received their first cancer treatment (median wait) within **50** days of referral whilst 95% of patients received their first cancer treatment within **140** days. the comparable figures for the previous quarter are **50** days and **132** days respectively. • Compared with Q1 of 2023, the median wait has remained the same and the waiting time within which 95% of patients receive treatment has increased by 2.2% (3 days). • In NHS Fife **69.5%** of patients started treatment within the 62-day standard [previous quarter **73.3%**]. SCAN **74.2%** and NHS Scotland **70.4%.** The **31-Day Standard** applies to all eligible referrals, regardless of route of referral and states that 95% of all patients will wait no more than 31 days from decision to treat to first cancer treatment: • In Scotland there were **6746** eligible referrals within the 31-day standard for this period, a **decrease** of **1.2%** on the previous quarter, but an increase of **5.6**% from the quarter ending 31 December 2019. • **94.1%** of patients started treatment within the 31-day standard, consistent with the previous quarter, but lower than **96.5**% in the quarter ending December 2019.	

		Action
	• The 31-day standard was met by 10 of the 15 NHS Boards: Golden Jubilee National Hospital, NHS Ayrshire & Arran, NHS Borders, NHS Dumfries & Galloway, NHS Fife, NHS Forth Valley, NHS Orkney, NHS Shetland, NHS Tayside, and NHS Western Isles. • For Scotland overall, **94.1**% of eligible patients started their first cancer treatment within 31 days of a decision to treat, the same as the previous quarter and very similar to the quarter ending 31 March 2023 (**94.0%**). This was a decrease from 96.5% in the last full quarter before the pandemic (ending 31 December 2019). • During the period January to March 2024, half of patients started their first cancer treatment (median wait) within **4** days of the date of decision to treat whilst 95% of patients started their first cancer treatment within **34** days; the comparable figures for the previous quarter are **5** days and **33** days respectively. • In NHS Fife **95.8%** (**92.8**% previous quarter) of patients met the 31-day standard. SCAN **94.2%** and NHS Scotland **94.1%.** The issues identified were: • **Staffing issues** – Due to annual leave, sickness and vacancy, delays have been seen throughout the pathways. • **Equipment Issues** – Issues with FDG supply and PET breakdown have created long delays within the Lung pathway. • **Facilities issues** – Delays to Oncology appointments affected patients diagnosed with prostate and lung cancer. Robotic theatre capacity issues have resulted in increased waits. Increased waits for CT Guided biopsies have affected the pathway for lung and renal patients. An increase in referrals has attributed to delays throughout the cancer pathways. • **Pathways issues** – Consistently routine staging and investigations contribute to breaches due to the number of necessary steps involved in the pathway for this quarter, particularly seen in the prostate, H&N and UGI pathways.	
7.2	**Quality Performance Indicators**	
7.2.1	**Oesophago-Gastric 2022**	
	AL went through the papers that were shared with the group. Case ascertainment for NHS Fife was 97.8%. NHS Fife met **14** of the **18** (including sub QPIs but excluding those reported by Board of surgery) QPIs for oesophago-gastric cancer.	

		Action
	QPI Not Met: • **QPI 1 Endoscopy - Histological diagnosis made within 6 weeks of initial endoscopy and biopsy** *(Gastric):* (2 cases) – One patient's pathology came back no malignancy; when discussed at MDT the decision was for BSC - clinical diagnosis. One patient omentum biopsy confirmed cancer from GI primary. • **QPI 4 (ii) TNM Treatment Intent recorded at MDT prior to treatment:** *(Oesophageal):* 4 cases. 3 patients declined treatment; 1 patient died before treatment. • **QPI 11 Curative Treatment Rates** *(Oesophageal).* 48 cases. *(Gastric).* 23 cases. There were no actions specific to NHS Fife identified.	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised following on from the figures provided at the last meeting, they now have 22 active studies. 11 are open to recruitment and 11 are in follow up. FQ noted the number of participants recruited since May is sitting at 80. This is in addition to the figure that was reported in May. The majority of them are coming through the nurse led prostate cancer pathway.	
9.	**REALISTIC MEDICINE**	
9.1	**Realistic Medicine Update**	
	SAS provided an update on behalf of EO'K and LMcG: • EO'K presented, and a discussion followed at the Cancer Leadership Group on 23/07/2024. EO'K explained the need to ensure systems aligned to deliver VBSC, that staff had the skills (all levels of training), time and resources to have the conversation and ensure consistency of language and that the patients/public felt empowered to be involved in the decisions but also their expectations were managed appropriately- i.e. a whole cultural shift and the need for national messaging which the Scottish Government is so far resisting. The interface between primary and secondary care was discussed along with realistic diagnostics. • Potential actions to explore included: – Cancer team showcasing stories about what works well – Adapt M&M meetings to include 'Realistic/good conversations' to spread realistic medicine – Champion leaders (Link realistic medicine and RTP) – Exploratory work around Patient Related Outcome Measures (PROMs)	

		Action
	• They are also working with comms to produce a staff and patient survey to explore the understanding of realistic medicine concepts to further develop training and support needs for the workforce and public to feel empowered to practice realistic medicine. • LMcG and Kingsley Oturu had a meeting with Primary Care Clinical Director Dr Answar to discuss how best to update Primary Care on realistic medicine. He has suggested a newsletter to be circulated which they are currently working on. They hope after this to be invited to GP Cluster Meetings. • In the newsletter they plan to focus on the promotion of the Questions that Matter (BRAN Questions) that are sent out with Outpatient Clinic Letters in Fife and the TURAS training module for staff to provide training in Shared Decision making. • Their project manager has spoken with several departments – radiology /surgical /oncology on how best to approach the utilisation tests that offer lower clinical values. • They have also met with patient experience to share idea on how their feedback aligns to the pillars of realistic medicine and looking to do some joined up work in the near future. • Overall, they are continuing to embed realistic medicine in all that they do in health and care in Fife.	
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Leadership Team (18/06/2024)**	
	This was noted by the group.	
10.2	**Cancer Performance & Delivery Board (30/05/2024)**	
	This was noted by the group.	
10.3	**Earlier Cancer Diagnosis Programme Board (21/06/2024)**	
	This was noted by the group.	
10.4	**SCAN Regional Data Reporting Group (25/06/2024)**	
	This was noted by the group.	
11.	**ITEMS TO NOTE**	
	No items to note.	
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	Cancer Framework Report to go the Clinical Governance Committee.	
13.	**ANY OTHER BUSINESS**	
	No any other business was discussed.	
14.	**Date of Next Meeting**	
	The next meeting will be on Thursday 31 October 2024, 14:00-16:00 via MS Teams	

DIGITAL AND INFORMATION BOARD

(Meeting on 23 July 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board
UNCONFIRMED

MINUTE OF THE DIGITAL AND INFORMATION BOARD HELD ON TUESDAY 23RD JULY 2024, VIA MS TEAMS

Present:

Chair - Dr Chris McKenna	Medical Director
Alistair Graham	Director, Digital & Information
Margo McGurk	Director of Finance & Strategy
Matt Valenti	Information Governance & Security Lead, Partnership Representative
Janette Keenan	Director of Nursing
Joy Tomlinson	Director of Public Health
Fiona Forrest	Acting Director of Pharmacy & Medicines

In Attendance:

Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance & Security
Helen Hellewell	Deputy Medical Director
Marie Richmond	Head of Digital Strategic Delivery, Digital & Information
Amanda Wong	Director, Allied Health Professions
Allan Young	Head of Digital Operations, Digital & Information
Claire Neal	(Minute) PA to Director, Digital & Information

Apologies:

Charlie Anderson	Head of ICT, Fife Council
John Chalmers	Clinical Lead, Digital & Information
Claire Dobson	Director of Acute Services
David Miller	Director of Workforce
Sharon Mullan	General Practitioner
Torfinn Thorbjornsen	Head of Information Services, Digital & Information
Audrey Valente	Chief Finance Officer on behalf of Director Health & Social Care

1	**Welcome and Apologies**	
	Dr McKenna welcomed everyone to the meeting, and it was noted that F Forrest has now joined as representation for Pharmacy & Medicines replacing B Hannan. Apologies were noted to the Board.	
2	**Minute and Actions of Meeting Held – 09.05.24**	
	Minutes were reviewed and agreed. A Graham provided an update to the outstanding items. • Item 3.1 – Paper will be presented to CGC in September. • Item 3.2 – New controls have been implemented and paper was provided to EDG in June 24. • Item 5.1 – Performance Report updated and in on Agenda for discussion. All actions have been marked as completed.	
3	**Matters Arising**	
	3.1 Asset Management Approach A Graham presented the Asset Management Approach to the Board and provided a brief overview of item.	

	Through ongoing work within the Reform, Transform and Perform (RTP) we have taken an approach on device management. These endpoint devices consist of Laptops, PC's, Monitors and Mobiles. This paper outlines and confirms the existing practice and includes some tightening of some of the rules due to cost implications. Through investigation we have seen many devices that are not connected to the network, and the organisation is not getting best use of these devices. We are encouraging staff to return unused devices to D&I for recycling or reassigning to another member of staff. If devices need to be reconnected to the network following a period of disconnection a service charge would be incurred by the service, to offset the time to reconnect and resecure the device. Through this ongoing amnesty work we have received around £46,000 of equipment returned, but we still have a significant amount that we could be better utilised. We are moving away from higher cost items such as Apple iPads and iPhones, and moving across to Android as these are cheaper to purchase, operate and replace. We still have IT systems that run on IOS e.g. Badgernet but these requests will be reviewed at time of purchase. A Graham provided further guidance on steps we propose for management of each device with cost savings actions. A lengthy discussion was undertaken on paper, noting a few of the comments from Board. • Very detailed paper, this is a great example of emphasising Grip and Control on spend with no detriment on how we deliver services. • An example was provided on previous issues with termination of mobiles and the contract terms, and the suggestions will be well received. A query was raised regarding the updated security feature for management of mobile devices and Microsoft products and accessing emails. A Graham provided an update to Board on the recent security changes, but noted the D&I teams would make direct contact. A discussion was held on the lifecycle of devices and a query was raised if we are aware of how many devices are possibly coming to end of life. A Graham replied once connected to network we can gather this information, and this then becomes part of Capital Lifecycle replacement. A Young noted we try to keep the cycle periods as low as possible generally every 5 years, but continued maintenance of this position is reliant of the availability of capital to support lifecycle replacement. This has decreased from the typical period of 8-9 years from the cyber events over the last few years. **Support** was provided for paper. **Action**: D&I to contact J Keenan to assist with issue with emails.	 **ALL** **AG**
4	**Risk Management**	
	4.1 Risk Management Report A Graham introduced item to the Board. The paper had been circulated in advance, sharing the overview of the risks within the last quarter. A Graham provided a brief update to risk report noting some of the below points: • There are currently 32 active risks and 4 risks have been closed since previous reporting and these were related to M365. • There are currently 9 high risks, 19 moderate and 4 low.	

	• Risks 1876, 2254 and 2341 of which are within tolerance, and they continue to be monitored. • We have 2 risks 1500 and 2410 which are linked to the Corporate Risk Register, for Cyber and Digital Strategy. All risks are constantly reviewed, and we focus our efforts against those outwith tolerance levels. A Graham provided a summary of additional risks with the high risks summary table. M McGurk queried risk 2322, Protecting Against Cyber Attack is at level 20, and is this high enough? A Graham provided explanation noting this can be reviewed. A brief discussion was held on the risk levels, and it was noted the figures in the infographic don't correspond with the risk table. A Graham will review and update for next meeting. A discussion was undertaken on the Cyber incident within Dumfries and Galloway and what the Health Board actioned to deal with attack. A Graham noted that a vulnerability due to employee action has been exploited. A conversation was held on what would NHS Fife would do and how would we work in the event of a Cyber-attack. A paper to be brought to EDG for discussion. Paper for **information** only. **Actions:** AG to review risk 2322 and it's current risk level. AG to update the risks in the infographic and the table as these don't match. AG to provide a paper to EDG on the NHS D&G findings.	 **AG** **AG** **AG**
5	**Performance**	
	5.1 D&I Performance Summary A Young shared the Performance Summary and advised work has been undertaken to review and improve metrics for KPI's, new definitions have been added. He provided update to the amendments, noting this is still a work in progress so this will evolve overtime. A brief update was provided to the metrics within Performance Summary noting the below: • We are working through the End of Life servers, and PCs that currently run Windows 10. It was noted the Digital Medicines Programme will assist to reduce this further. • Work progressing well with the measured implementation of Windows 11. • Cyber Score, we report on two different scores Server and Endpoint. We are currently transitioning from one product to a National one and these will combine both elements, so this will be easier to protect. • We are working with the service to provide better metrics. A Young provided background to IT Changes, and this can be a lengthy process sometimes taking an Engineer a day to review. Metrics for this will appear as we progress with Performance Summary. J Tomlinson noted great work and fantastic to see the overview of workload. She raised a regarding the SMR01, and the change in figures. A Young confirmed unsure but ensure he will seek to have the person that can answer be available at next meeting.	

	A Graham presented a slide on other measures they are considering on adding, and opened to Board if there were any measures for general consideration, including Clinical Safety measures. A brief discussion was undertaken on the issues with back to referrer. Dr McKenna raised an issue with letters waiting to be verified as there is no notification to advise a Clinician. A Brown queried if the status of D&I Policies and Procedures will be included. A Graham noted these will be included in future iterations. M Richmond advised NHS Fife, have been applauded for the work with Clinical Safety. All Senior Nurses are undertaking Clinical Safety Courses, and we are taking learning from NSS. **Action**: Query re SMR01's figures, explanation provided at next meeting. No other comments were raised. Paper for **information** only	 **AY**
6	**Strategy and Programmes / Project**	
	6.1 Strategic Delivery Update M Richmond introduced item and provided an update to a few of the items within the Strategic Delivery update. A brief update is noted below: **Executive Summary**: We are currently experiencing challenges, along with the organisation, caused by staff turnover and recruitment delays. M Richmond provided feedback on other projects and reiterated the issues with resourcing, with staff retiring or leaving. Dr McKenna noted issues with recruitment and resource, but this will be left for A Graham to address out with this meeting with appropriate parties. **National Programmes**: **eRostering**: BAU team now agreed, and recruitment due to commence. Working closely on SafeCare. Work continuing. **GPIT**: Challenges with timescale from National, and this is having an impact on delivery and planning. Current work is ongoing with the business case. There was a brief discussion regarding the concerns raised. **LIMS**: Challenges with supplier but working through. Working with National for Phase 2, a meeting was held last week so moving forward. **CHI**: Delays with National, and the timelines. This is currently being reviewed. **Welch Allyn**: Positive feedback received but this was only agreed for 30 days so work to be undertaken on funding availability. **HEPMA**: Continue to have challenges with supplier but discussions are ongoing, and we have received positive feedback. M Richmond noted the team continue to work hard on other projects currently being undertaken. A lengthy discussion was held on all the projects that are being undertaken at present and detailed with update. Dr McKenna noted it appears that we are trying to do everything and as noted previously a review on what is priority. M Richmond noted majority of undermentioned are Nationally directed and we	

	need to do. M Richmond provided feedback to challenges, but we do our best to prioritise. No other comments were raised. Paper for **noting** only.	
	6.2 Strategic Framework A Graham noted paper presented to Board for decision and provided a brief background to paper. Work has commenced on the revised Digital Strategy, however there are challenges Nationally. We hope to provide a Digital Framework that will bring focus on overarching elements to the organisation. Every National programme has significant delays and Boards are looking to work Regionally rather than Nationally. Proposal is to focus our attentions to shorter term. At the next meeting a strategic delivery will be presented. A Graham further detailed information from item. A discussion was held on issues discussed in previous items regarding issues with delivery and suppliers etc. Dr McKenna provided an overview of discussion within meeting and asked for a report to detail the current situation on projects that are running, and the risks in relation to these. A discussion to continue offline with Dr McKenna and A Graham to address these points on what and how this is presented to EDG. No other comments were raised. Paper **not** agreed with further discussions to be undertaken.	
7	**Escalation to Clinical Governance Committee (via EDG)**	
	It was noted a paper to be escalated to EDG on the concerns regarding project delivery.	
8	**AOCB** There was no other competent business. Dr McKenna noted the challenges discussed within meeting and the level of work required to continue to progress matters. Dr McKenna thanked for attendance, participation in meeting and for all the continued hard work.	
9	**Date of next meeting** Tuesday 15th October 2024, 0900, via MS Teams	

AREA DRUG & THERAPEUTICS COMMITTEE **(Meeting on 21 August 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 21 AUGUST 2024 AT 2.00PM VIA MICROSOFT TEAMS

Present: Ms Fiona Forrest (Chair)
Ms Lynn Barker
Dr Caroline Bates
Dr Iain Gourley
Dr Sally McCormack
Ms Mairi McKinley
Mr Fraser Notman
Ms Amanda Wong

In attendance: Mr Ryan Headspeath (agenda item 6.5)
Ms Victoria Robb (agenda item 7.1)
Mr Duncan Wilson (agenda item 10)
Ms Sandra MacDonald, Administration Officer (minutes)

		ACTION
1	**WELCOME AND APOLOGIES FOR ABSENCE**	
	Ms Forrest welcomed everyone to the August meeting of the ADTC.	
	Apologies for absence were noted from Dr David Griffith; Dr Helen Hellewell; Dr John Morrice; Olivia Robertson; Rose Robertson; Mr Satheesh Yalamarthi.	
	It was confirmed that the meeting was quorate.	
2	**MINUTES OF PREVIOUS MEETING ON 19 JUNE 2024**	
	No issues were identified with the minutes from the meeting on 19 June 2024. Minutes to be circulated to ADTC members who were present at the meeting on 19 June for final ratification.	**SMacD**
3	**ACTION POINT LOG**	
	It was noted that all action log items scheduled for update have been included on the agenda.	
	Submissions to MSDTC for non-Formulary items – reminder of governance route Ms Forrest updated the Committee on discussions with the MSDTC/ADTC secretariat. The medicines governance structure and Terms of Reference for the MSDTC and ADTC to be refreshed and brought to the ADTC meeting in October for discussion.	**FF**

4 ANY OTHER MATTERS ARISING FROM THE MINUTES

There were no other matters arising from the minutes.

5 DECLARATION OF INTERESTS

There were no declarations of interests.

6 ADTC SUB-GROUP UPDATE REPORTS

6.1 East Region Formulary Committee

Mr Notman introduced the update report from the East Region Formulary Committee (ERFC) and highlighted key points.

The ADTC noted that a pre-ERFC stop and assess panel has been established to provide a robust process for scrutiny of the implications of Formulary applications within patient pathways and provide advice to the ERFC.

The ERFC is actively seeking new members to ensure that there is fair representation across the three Boards. The ADTC noted the communication produced by the ERF team which outlines the role and commitment involved and supported circulation of this within the Health and Social Care Partnership and the Acute Service. The ADTC noted that a Co-Chair from NHS Borders has been appointed; a Co-Chair from NHS Fife is still to be identified. The ADTC also noted that the NHS Fife Formulary Pharmacist is continuing to provide support for the ERFC professional secretary role.

The ADTC noted that there are ongoing discussions with a view to streamlining the ERF. One of the proposals being considered is that access to medicines of low usage should be via individual Board non-Formulary processes rather than inclusion on the ERF. A discussion followed and it was acknowledged that although the Non-Formulary Request process was appropriate for certain indications/ medications to provide greater scrutiny and governance, there are additional workload implications associated with this process.

The ADTC noted the importance of robust clear guidelines to underpin and support identification and choice of medicines within the ERF.

Ongoing discussions at the ERFC about its remit and function in relation to clinical and financial aspects of Formulary Applications were highlighted. Further discussions between the three Boards around the approval process are continuing and feedback will be provided to the ADTC in due course. The good grip and control of financial implications of medicines in NHS Fife through the Fife Prescribing Forum and the RTP Medicines Optimisation Board was highlighted.

The ADTC noted the comprehensive update from the East Region Formulary Committee. The ERFC communication regarding call for new members to be **AM**

distributed across the Health and Social Care Partnership and Acute Service. Mr Notman to discuss ERFC Co-Chair role with Dr Hellewell and Dr McCormack. **FN/HH/SMcC**

6.2 MSDTC

Dr McCormack introduced the update report on behalf of the MSDTC and highlighted key points.

The report detailed the guidelines that have been approved and provisionally approved. The ADTC noted that the guideline for inhaled methoxyflurane (Penthrox®) for adult trauma patients with moderate to severe pain has been approved by the MSDTC. This will be implemented following further governance processes and approval through the Medical Gas Committee. The ADTC also welcomed approval of the Rapid Tranquilisation guideline.

The ADTC noted that all areas are aware of MSDTC processes and a guideline tracker has been produced to facilitate streamlining of the guideline checking process prior to discussion at MSDTC.

The ADTC noted that discussions are ongoing to refine inclusion/ exclusion criteria for submission of guidelines to MSDTC and review the Terms of Reference. A request for additional membership due to recent role changes within Pharmacy was highlighted. It was agreed that this should be deferred pending review of the Terms of Reference. The updated Terms of Reference for the MSDTC and ADTC to be brought to the ADTC in October. **FF/SMcC/AM**

The ADTC noted the update on behalf of the MSDTC and the breadth of work that is progressed through the Committee.

6.3 Fife Prescribing Forum

Mr Notman introduced the update report on behalf of the Fife Prescribing Forum and highlighted key points.

The Fife Prescribing Forum is a long-standing group that invites specialties to attend and present the work ongoing within their area around implementation of new medicines, identification and management of financial risks within prescribing, potential benefits of medicines optimisation and opportunities for efficiencies.

A template has been produced to standardise the quality of reports presented to the Forum. There is good engagement from all Specialties and excellent service update reports presented.

A robust process for tracking actions has been established. Actions identified during meetings are captured within an Action Tracker which is held on the Teams Channel and named individuals are assigned to progress and update the Action Tracker accordingly.

The ADTC noted the challenges due to pressure on all areas and the actions taken to amend meeting dates where required to facilitate attendance.

It was noted that the Prescribing Forum has dual reporting through the ADTC for the overall use of medicines and clinical practice and through the RTP Medicines Optimisation Board, from a medicines efficiencies aspect.

The ADTC noted the update on behalf of the Fife Prescribing Forum. An overview of the detail within the workplan including potential reviews of any areas of clinical practice to be brought to the next ADTC. The refreshed Terms of Reference should also be submitted to the next ADTC for formal ratification. **FN**

6.4 Non-Medical Prescribing Group

Ms McKinley introduced the update report on behalf of the Non-Medical Prescribing (NMP) Group and highlighted key points.

The ADTC noted the successful launch of the new Non-Medical Prescribing Policy in June 2024. Further work is required in some areas to support services around the processes for NMPs and use of the Policy supporting tools. An NMP study day as well as education sessions and networking events for sharing examples of best practice are being organised. A repeat of the NMP survey and scoping of policy awareness is planned for early 2025.

It was highlighted that confirmation of a reduced level of NMP module funding from NES has been received (targeted at specific areas such as Mental Health and Urgent Care). Services are also actively encouraged to support and provide funding to enable individuals to undertake the NMP module.

An issue with potential employment of locum NMPs within GP Practices and the governance process around this was highlighted. There have been initial discussions at the LMC/GP Sub-Committee around potential development of a process similar to the local performer's list however greater clarification around this is required. Further discussion to be taken forward off-line and an update brought back to the ADTC in due course.

The ADTC noted the update on behalf of the Non-Medical Prescribing Group and the good progress made. **MM**

6.5 Shared Care Group

Mr Headspeath introduced the update report on behalf of the Shared Care Group and highlighted key points.

The ADTC noted ongoing good engagement with specialist services in order to ensure extant Share Care Agreements (SCAs) currently in use remain safe and appropriate. Significant progress has been made with the development of the cross-speciality SCAs for methotrexate and hydroxychloroquine. The methotrexate SCA is in final draft format and submission to the GP Sub-Committee in September is proposed. The hydroxychloroquine SCA has been

discussed at the GP Sub-Committee and feedback from the Specialty in response to comments received is awaited.

It was noted that review and update of the lithium SCA is currently in progress. Following initial discussions at the June ADTC, clarification around the model of care is awaited, and will come back to ADTC in October.

The workplan going forward includes formulation of a plan for review and update of extant protocols in collaboration with specialist services as well as moving forward with the development of the SCA for valproate medicines.

A discussion ensued around the safety review of extant SCAs. It was noted that initial action was taken to prioritise the methotrexate SCA and work to update the remaining extant SCAs is now progressing at pace. Mr Headspeath to clarify the status of the review of the extant SCAs to provide assurance to the ADTC that **immediate action** is being taken in relation to review of any SCAs that are deemed to be unsafe. **RH**

The ADTC thanked Mr Headspeath for his leadership in taking forward the review of SCAs and noted the good progress made.

7 SBARs

7.1 Controlled Drugs Accountable Officer Annual Report

Ms Robb introduced the Controlled Drugs Accountable Officer (CDAO) SBAR and CDAO Annual Report 2023-24 and highlighted key aspects.

The report has been discussed at the Pharmacy Senior Leadership Team, CDAO Group and Clinical Governance Oversight Group. Following discussion at the ADTC the report will then be submitted to the Executive Directors Group and Clinical Governance Group.

Ms Robb provided a brief overview of the background to the report. The report outlines the roles and responsibilities of the CDAO and the work ongoing to ensure the safe and effective use of controlled drugs (CDs) within Fife.

A programme of CD Assurance Assessments is undertaken to ensure that every ward/department holding CDs in NHS Fife receives a six monthly Pharmacy visit, to assess compliance with legal and best practice requirements. The report provides a breakdown of the results of compliance with Assurance Assessments, highlights areas of good practice as well as areas for improvement and proposed actions. Individualised action plans are developed for each area/ward/department and implementation is progressed by the Senior Charge Nurse or equivalent, with oversight via Heads of Nursing and local governance processes within the Acute Service and Health and Social Care Partnership.

The report provides a breakdown on the reporting of CD incidents across the Acute Service, Health and Social Care Partnership and Community Pharmacy

and the learning taken forward. The report demonstrates a good reporting rate with a low proportion of harm.

The report also provides an update on the CDAO workplan for 2023/24 and outlines priorities for the 2024/25 workplan going forward.

The ADTC noted the CDAO Annual Report 2023/24 and concurred that it provided a significant level of assurance with regard to fulfilment of the responsibilities of the NHS Fife Controlled Drug Accountable Officer. The ADTC thanked all those involved for their support and for the work ongoing to ensure the safe and effective use of CDs within Fife.

8 Risks Due for Review in Datix

Mr Notman took the ADTC through the risks scheduled for review and agreed current risk levels, further management actions required and risk review dates.

Risk 1347 - Shared Care Protocols
The ADTC discussed the current RAG status and agreed that this should remain as red pending confirmation of assurance on the safety aspect of expired Shared Care Protocols.

Risk 1504 - Lack of a Central IT Location to Store Guidance Documents
Mr Notman provided an update on the work ongoing to identify guidance documents relating to medicines on StaffLink and apportion these to relevant Specialties. An issue around inadequate document control and lack of clarity around approval processes for a number of the guidance documents was noted. The next step is working with the Communications Team to transfer the guidance documents on to a central repository. The ADTC noted the progress made around establishing the central repository and agreed that further detail was required around the review process. Mr Notman to discuss off-line with the Co-Chairs of the MSDTC. It was agreed that the current risk level should remain unchanged.

Risk 1575 - Input into Medicines Management and Governance
The ADTC noted recent difficulties with confirming the meeting quorate and agreed that this risk should remain open at present. ADTC Terms of Reference, membership and attendance register to be reviewed and brought to the ADTC for consideration.

Risk 1621 - Medicine Shortages
The ADTC was assured by the work undertaken and processes introduced to minimise the risk resulting from medicine shortages. The ADTC also noted the review and implementation of the Medicines Shortage Policy and associated Problem Assessment Group paperwork. It was agreed that the current RAG status should remain unchanged.

Risk 2304 - East Region Formulary
Mr Notman provided an update on the management actions. It was noted that there has been no progress with regard to regional work around Formulary

compliance and reporting. An NHS Fife process for Formulary compliance reporting will be established and shared with the other teams within the East Region. The ADTC was content with the actions and current RAG status. A review of the wording around the risk was noted.

ADTC risks to be brought back for review as scheduled. Risk owner to be amended to Fiona Forrest. **FN**

9 EFFECTIVE PRESCRIBING

9.1 Consultation - Achieving Value and Sustainability in Prescribing

Mr Notman highlighted the Scottish Government Consultation on the draft Guidance - Achieving Value and Sustainability in Prescribing and briefed the ADTC on the background to this. It was noted that although the consultation is open to ADTC members to review and respond, the guidance is particularly relevant to GP Practice colleagues.

The ADTC noted the Scottish Government Consultation of the draft Guidance – Achieving Value and Sustainability in Prescribing. Further detail around implementation to be brought back to the ADTC in due course. Dr Gourley to arrange for distribution of the Consultation to GP Practices. **IG**

10 HEPMA and EIDD Update

Mr Wilson provided an update on progress with implementation of HEPMA, the Pharmacy Stock Control System and Electronic Immediate Discharge Document (eIDD) within NHS Fife. The projected timeline for the roll out of HEPMA is August 2025-August 2026, with rollout out of the Pharmacy Stock Control System and eIDD prior to this. Detailed project plans are currently being finalised.

The ADTC noted the digital medicines programme update and thanked Mr Wilson and the Digital and Information team. Detailed plan on prescribing aspects to be brought to the ADTC in due course.

11 PACS/SMC Non Submissions

11.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

12 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

12.1 Yellow Card Centre Scotland Annual Report

The ADTC noted the Yellow Card Centre Scotland Annual Report.

13 ESCALATIONS / POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee. The ADTC acknowledged the current risk levels discussed under item 8 and was assured by the actions underway to mitigate the risks. It was agreed that no further escalation was required with regard to this item.

14 ANY OTHER COMPETENT BUSINESS

There was no other competent business.

<u>**Other Information**</u>

a **Minutes of Diabetes MCN Prescribing Group** - next meeting September 2024.

b **Minutes of Heart Disease MCN Prescribing Sub-Group -** next meeting September 2024.

c **Minutes of Respiratory MCN Prescribing Sub-Group 31 July 2024** - not available at present.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 23 October 2024 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 9 October.

HEALTH & SAFETY SUBCOMMITTEE

(Meeting on 6 September 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Minute of the H&S Sub-Committee Meeting
Friday 6 September 2024 at 2 pm on Teams

Present
Neil McCormick, Director of Property & Asset Management (Chair) (NMcC)
David Miller, Director of Workforce (DM)
Claire Dobson, Director of Acute Services (CD)
Dr Chris McKenna, Medical Director (CMcK) (left at 2.30 pm)

In Attendance
Billy Nixon, H&S Manager (BN)
Nicola Robertson, Director of Nursing (for Janette Keenan) (NR)
Lynn Parsons, Employee Director (LP)
Andrea Barker, Executive Assistant to the Director of Property & Asset Mgmt (Minute)

The order of the minute may not reflect that of the discussion
The meeting was recorded on Teams

No.		Action
1	**Welcome & Apologies** NMcC welcomed members of the Sub-Committee to the meeting. Apologies were received from Ian Campbell and Paul Bishop.	
2	**Minute/Matters Arising**: The Minute of 7 June 2024 was **approved** as an accurate record. Action Item 8.1 Radon Monitoring, Kinghorn Health Centre NMcC advised that he was aware of re-sampling having taken place and all results are satisfactory. 5-year testing cycles will now re-commence. Action now complete. Action Item 4.1 Self-Harm Ligature Risks In terms of patient self-harm incidents, it would be helpful to identify the cause of incidents ie personal items including headphones, a belt etc or fixed environmental points. BN has agreed to prepare a report containing a breakdown of whether self-harm incidents were caused by personal or environmental items for distribution to the Sub-Committee. This will be prepared as a one-off document.	**BN**

Unconfirmed

3 Governance Arrangements:

There were no governance arrangements to report.

4 Operational Updates

4.1 H&S Incident Report (June - August 2024)

The H&S Incident Report for the period June 2024 to August 2024 was distributed and noted by the Sub-Committee.

Sharps (staff)
29 reported incidents in the quarter, of which:

12 incidents - no harm
14 incidents - minor harm
3 incidents - moderate harm

Note - there were 8 Sharps Incidents reported with NO SBAR attached.

Slips, Trips & Falls (staff)
20 reported incidents in the quarter, of which:

6 incidents - no harm
10 incidents - minor harm
4 incidents - moderate harm

Violence & Aggression (staff)
372 reported incidents in the quarter, of which:

272 incidents - no harm
72 incidents - minor harm
26 incidents - moderate harm
1 incident - major harm
1 incident - extreme harm

Incidents reported to Police = 47
Incidents reported as sexual assault/harassment = 28
Incidents reported as hate crimes = 11

Musculoskeletal (staff)
9 reported incidents in the quarter, of which:

3 incidents - no harm
5 incidents - minor harm
1 incident - moderate harm

- load handing = 3
- patient handling = 6

Self-Harm (patients)
64 reported incidents in the quarter, of which:

30 incidents - no harm

Unconfirmed

	20 incidents - minor harm 8 incidents - moderate harm 1 incident - major harm 5 incidents - extreme harm **<u>Riddor</u>** (all) 9 reported incidents in the quarter, of which: 1 incident - minor harm 6 incidents - moderate harm 2 incidents - major harm 4.2 <u>H&S Heads of Service Riddor Reporting Exercise</u> BN - Riddor Reportable information over the past 5 years was gathered from Scottish Boards identifying varying numbers of Riddor incidents across Scotland. It was **agreed** that the report be distributed to Sub-Committee members for information. <u>Action</u> - BN agreed to distribute. 4.3 <u>H&S Sub-Committee Incident Report - Request from the Area Partnership Forum (APF)</u> Recently, the APF has requested the Incident Report feature as a standard agenda item at future APF meetings, to which the Sub-Committee agreed. LP thanked the Sub-Committee and welcomed BN for agreeing to attend and present the H&S Incident Report, paying particular attention to the Self-Harm Incidents section in terms of ligature risk, at the next meeting on 18 September 2024. 4.4 <u>Organisation Learning Group</u> (OLG) NR advised that at a recent OLG meeting, a discussion took place around violence and aggression in terms of conducting preventative work. She added that due to the high number of recorded incidents in Nursing, what action is being taken to protect staff and reduce these incidents from happening in the future? A discussion followed on body worn cameras with the focus being on initially considering the introduction of these in areas that display higher numbers of incidents month-on-month. NMcC added that of the violence and aggression recorded incidents, 88% of these happen in the Health and Social Care Partnership and of these, there are several hotspots where incidents regularly occur in a small number of areas. The Sub-Committee were happy to support the OLG in wider discussions.	**BN**

Unconfirmed

	4.5 Reinforced Autoclaved Aerated Concrete (RAAC) Update NMcC advised the Sub-Committee that a paper going to the Staff Governance Committee today with updates, as the discovery surveys are now complete over the seven blocks that have been identified the presence of RAAC across the NHS Fife portfolio,. The Estates team was pleased to report that there had been no further degradation of the identified RAAC, adding that it remains in the same condition as it did one year ago, with no signs of water ingress or further decomposition. He added that at this stage, there is no further risk to patients, staff or visitors. The Scottish Government will issue guidance in the near future which will support the actions that NHS Fife has recently undertaken. 4.6 Sharps Review Update BN advised that Sharps Audits continue on sites across NHS Fife. Anonymous reporting has been taking place and feedback, albeit, slow is filtering through. Recognition of the Sharps Policy is underway with a refresh to several pieces of sharps communication. Sharps information and policy guidance is available to access on Blink.	
5	**NHS Fife Enforcement Activity** There was no enforcement activity to report within NHS Fife. Enforcement activity by the HSE continues in several Boards throughout Scotland, particularly around ligature contraventions. NMcC added that he was pleased with the progress of work around improving the anti-ligature situation in mental health facilities in Fife. He added that, as a Board, we should remain mindful not only to the possibility of prosecution from the Mental Health Welfare Commission but also prosecution from the Health & Safety Executive who are another interested party. BN advised that mental health patients are often admitted to Acute wards for medical treatment, which are not identified as ligature free wards. He added that conversations with nursing staff have identified concerns around the fact that they have no mental health training. BN agreed to provide members of the Sub-Committee with anti-ligature updates in order to keep everyone informed of progress. The Anti-Ligature Policy has recently been approved and will be available to staff on Blink.	

Unconfirmed

6	**Policies & Procedures** 6.1 Surveillance Policy The Surveillance Policy is currently with Occupational Health colleagues for review. 6.2 Manual Handling Policy The Manual Handling Policy is being completely rewritten to tie in with the Manual Handling teams way of working. Due for completion by the end of September 2024. 6.3 Lone Working Policy LP advised the Sub-Committee that work continues on the Lone Working Policy particularly around the HSCP and community hospital settings. Staff are being consulted on how they feel the policy will impact in services and individual areas. LP added that she was looking forward to receiving feedback in due course.	
7	**Performance** 7.1 ASD&CD H&S Committee Update • The ASD&CD H&S Committee Minute of 20 May 2024 was circulated to the Sub-Committee for noting. • CD advised the Sub-Committee that she and Andy Verrecchia (AV) are handing over the Chair of the ASD&CD H&S Committee to Paul Hayter and Mimms Watts. This arrangement was agreed to be actioned once the group was established. NMcC on behalf of the Sub-Committee extended his thanks to CD, AV, and colleagues for their hard work in getting the meeting up and running. • CD advised that the next ASD&CD H&S Committee meeting will take place on 18 November 2024. 7.2 HSCP H&S Assurance Group Update • The HSCP H&S Assurance Group minute of 30 April 2024 was circulated to the group for noting. • There was no representation at the meeting today from the HSCP.	
8.	**Any Other Business** There was none.	
9	**Date & Time of Next Meeting**	

Unconfirmed

	Friday 6 December 2024 at 1 pm on Teams.	

INFORMATION GOVERNANCE AND SECURITY STEERING GROUP **(Meeting on 17 July 2024)**
ICO Response to St Andrews Community Hospital Incident. (Completed - September 2024 CGC meeting)

NOTE OF THE INFORMATION GOVERNANCE AND SECURITY STEERING GROUP HELD ON WEDNESDAY 17TH JULY 2024, 0900, VIA MS TEAMS

Present:

Chair - Margo McGurk	Director of Finance & Strategy/ Deputy Chief Executive
Susan Fraser	Director of Planning and Performance
Alistair Graham	Director Digital & Information
Janette Keenan	Director of Nursing
Helen Hellewell	Deputy Medical Director
David Miller	Director of Workforce
Frances Quirk	Assistant RIK Director
Joy Tomlinson	Director of Public Health
Audrey Valente	Chief Finance Officer on behalf of Interim Director of Health & Social Care

In Attendance:	
Andy Brown	Principal Auditor
Margaret Guthrie	Head of Information Governance and Security / DPO
Gillian MacIntosh	Head of Corporate Governance
Kirsty MacGregor	Director of Communications
Allan Young	Head of Digital Operations, Digital & Information
Claire Neal	(Minute) PA to Director, Digital & Information
Apologies:	
Claire Dobson	Director of Acute Services
Dr Chris McKenna	Medical Director
Elizabeth Gray	Patient Relations Officer (on behalf of head patient relations)
Benjamin Hannan	Director of Reform & Transformation
Brian McKenna	HR Manager
Sharon Mullan	General Practitioner

1	**CHAIRPERSON'S WELCOME AND APOLOGIES**	
	M McGurk welcomed everyone to meeting and apologies were noted.	
2	**MINUTE & ACTIONS OF PREVIOUS MEETING 16TH April 2024**	
	Minutes were reviewed, and agreed they were a true record, and actions were discussed and updated accordingly, it was noted actions were on Agenda for completion.	
3	**MATTERS ARISING**	
	3.1 ICO Response to St Andrews Community Hospital Incident M McGurk thanked for the paper, noting this was a clear update to the ICO incident. M Guthrie replied that all actions are concluded, and the paper is for assurance to the Group. NHS Fife have submitted all correspondence to ICO, and ICO have acknowledged the submission. G MacIntosh noted this was also discussed at Clinical Governance Committee (CGC) and there was a disclosure in the Annual Report. For the next CGC could a paper be provided with confirmation from ICO this has been closed. A Graham also noted this will follow in the next IG&S Report and meeting. **Action** – Update to be provide to the Clinical Governance Committee at their next meeting.	**MG/ AG**
	3.2 Device Management Policy SBAR	

	A Young provided a verbal update to this item noting the below: • A decision was made, that we would deploy on the technical use of systems rather than individual devices. We can control systems that staff can access better rather than trying to control devices. This will also comply with the NIS Audit. • We are currently reviewing the technical systems and there are around thirty. We have restrictions in place, e.g. MFD and can encrypt data providing safe access. This will take time to fully implement but will continue to update Group on the progress. M McGurk noted this is a pragmatic and reasonable way forward as per previous discussions at the last IG&S Steering Group. There were concerns raised on being able to fully control personal devices. A Graham highlighted that staff may have already started to see these controls in place, as this is being implemented alphabetically. No further comments were raised. Paper for **noting** only. **Action:** AY will provide update at next Steering Group.	**AY**
4.	**Risk Management**	
	4.1 Risk Management Report A Graham shared item on screen and provided a brief update to this quarter report for July 24. A few of the below points were highlighted: • There are currently 9 high risks, 16 moderate and 5 were low. • This is improvement since the last report, with high and moderate risks but no change to low. • There are no risks that have deteriorated, but there are number of risks that have improved e.g. 1932, 2855. • Risk 2950 is a new risk; IG Team have added this risk to Datix, and this continues to be monitored. • As we move to the new framework, this will advise on the whole of D&I risks and not just Information Governance. All risks continue to be monitored to ensure they remain at their current reported risk rating and the target level remains appropriate. F Quirk raised a query on the use of mobile phones and the capability of the corporate devices. It was noted that staff may choose to use their personal devices for work purposes as these sometimes have more functionality to the standard issue of basic phones. A Graham replied that all mobiles should have a suitable functionality so the team would reach our directly to understand if that isn't the case. Top end devices are removed due to the cost implications. It was agreed that that the matter would be progressed directly with F Quirk and her team. A brief discussion was undertaken on staff using mobile devices out with office hours and the need to balance this with staff wellbeing. F Quirk noted their staff are on the move and not always office based. M McGurk thanked for the clear and concise reporting. No further comments were raised.	

	Assurance was noted.	
5	**Information Governance and Security Assurance and Accountability Framework**	
	5.1 IG&S Assurance and Accountability Framework Review A Graham provided a brief overview to items within the Assurance and Accountability Framework noting some of the below points: • There are 10 categories within the IG&S Accountability and Assurance Framework (IGSAAF), these also are in connection with ICO Accountability Framework and Cyber Assurance Framework. • Three incidents were reported to ICO in the last period, with one remaining active with the ICO. • There has been a small percentage increase for mandatory training uptake across the organisation. • There are 2 policies due within the next 2 months for review and approval. GP/R4 and GP/F1. • Information Governance team have an extensive training programme that is available for individuals to access. This continues to be delivered. • Ongoing work is being undertaken with suppliers on information sharing agreements. • DPIA's training continues for guidance on completion. • Progress is being made with the NIS actions, as the audit is due during July and August. • We continue to track and monitor our improvement actions. M McGurk thanked A Graham for update and noted this provides robust reporting and provides a clear paper and is always good to navigate through the topics easily. A query was raised regarding FOI's and the current review process. J Tomlinson noted she would like to be included within the review as there can be many responses, and she feels we can be quite generous with our information that we are providing compared to what Boards are expected to provide. A brief discussion was held on the submission and FOI's review and who is to be included with review. Noting H Hellewell for H&SCP and F Quirk from Research, Knowledge and Innovation. M Guthrie advised happy for all contributions as work is always continuing for improvements with FOI's. M Guthrie updated Group on training provided to departments and can be tailored to the individuals requirements. It was noted that a conversation to be taken offline with interested parties. A brief discussion was held on the DPIA and external components on what we can control. M Guthrie replied we can ensure this is managed with suppliers and through the asset register. No other comments were raised. **Assurance** was noted.	
	5.2 Records Management Project Update M Guthrie provided an update and a brief overview to current position for Records Management. A few of these points are noted below: • RTP is increasing activity levels for services relocating, and the teams are having to provide support to minimise the risks around relocating and the closure of buildings where paper records exist. Mitigations are in place to combat but we need to ensure areas are fit purpose and assess the risks.	

	• An updated progress report was provided to the National Records Scotland on progress with the Records Management Plan. Initials findings is they are very pleased with the progress being made within NHS Fife. M McGurk thanked for update to paper and great to see initial feedback is positive. Also, thanks provided to IG Team for their amazing work and what is happening here is being replicated in other Boards. Other comments were reiterated on the great work achieved and where this meeting is presently to before is to be congratulated. No other comments were raised. Paper for **information** only.	
6.	**ITEMS FOR ESCALATION TO CLINICAL GOVERNANCE COMMITTEE**	
	It was agreed there was no formal escalation to CGC, but to provide an update to ICO response to item 3.1.	
7.	**AOCB**	
	7.1 IG&S Operational Group Minutes – 11/06/24 For **noting** only to Group. M Guthrie offered thanks to the Steering Group for all their feedback, as this helps the IG Team. M McGurk closed meeting by providing thanks for all the hard work, papers are strong and evidenced on how much has been progressed.	
8	**DATE OF NEXT MEETING:** Tuesday 22nd October, 0900, via MS Teams	

MEDICAL DEVICES GROUP

(Meeting on 11 September 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Minute Medical Devices Group
Wednesday 11 September 2024 at 2 pm on Teams

Present

Neil McCormick, Director of Property & Asset Management **(Chair)** (NMcC)
Iain MacLeod, Deputy Medical Director (IMacL)
Iain Forrest, Medical Physics Manager (IF)
Julia Cook, Infection Control Manager (JC) (joined at 2.10 pm)
Claire Steele, Head of Pharmacy, Medicines Supply & Quality (CS) (joined at 2.20 pm)
Robyn Gunn, Head of Laboratory Services (RG)
Alistair Graham, Associate Director of D&I (AG)
Mike McAdams, Estates Compliance Manager (MMcA)
Richard Scharff, Radiology Clinical Activity Manager (RS)
Kevin Booth, Head of Financial Services & Procurement (KB)

In Attendance

Miriam Watts, General Manager, Directorate Office Planned Care (MW)
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 Gemma Couser, Maxine Michie, Rose Robertson (Tracy Gardiner), Nicola Robertson, Elizabeth Muir.	
2	**MINUTE OF LAST MEETING/MATTERS ARISING** The Minute of 12 June 2024 was **a**pproved by the group.	
3 3.1	**GOVERNANCE** Medical Devices Group Terms of Reference NMcC advised that there is a national Terms of Reference (ToR) style that has been circulated by the Chief Medical Officer around good governance around medical devices and how this should work.	

	Recently, we have adapted our existing ToR to the 'good practice' version. The group agreed for an updated version to be circulated in due course. Action - Andrea to circulate. The adapted Tor will fit in with the paper that is being produced by NMcC, IMacL and GC which is following the UK Medical Devices Regulation being developed as a national Action Plan.	**Andrea**
3.2	<u>Medical Devices Workshop Update</u> NMcC recently attended a Medical Devices Workshop at the Golden Jubilee National Hospital, Clydebank on 13 August 2024. The Chief Medical Officer and various SG representatives were in attendance. Slides from the workshop were shown and discussed with the group. Following discussions at our last meeting, we are now beginning to understand and gain more clarity around what the requirement is from SG for medical devices.	
3.3	<u>Medical Devices Policy</u> In terms of a Medical Devices Policy exercise, recently carried out by twenty-two Health Boards, NHS Fife was one of seven Boards who had a policy in place, albeit focused on the procurement of medical equipment as opposed to looking at the wider impact of medical devices. We await feedback on this. NMcC advised that Mike McAdams will take this forward with helpful support from Bryan Hynd, NHS Forth Valley.	
4	**<u>FOR DISCUSSION</u>**	
4.1	<u>Medical Devices SBAR with Appendix 1 Medical Devices Policy Framework & Action Plan 2024-26 (at FCGC on 3 May 2024</u>) We have outlined our position in the SBAR in terms of everything that has been carried out to date and moving forward for our compliance with the new regulations.	
4.2	<u>Scan for Safety Update</u> The Scan for Safety Programme links to patients and focuses on orthopaedics, ophthalmology, interventional radiology and cardiology. These specialties who use implantable devices will be the first to be implemented within every board within the next two years.	

Unconfirmed

	Gemma Couser continues to lead the discussions with SG for Scan for Safety. In terms of linking implants to patients, their patient data ie their CHI number is linked to any implants using handheld scanners. This will give a good indication of every device implanted in our patients going forward. In the future, patients will be able to register on the system and find out what implants they have had fitted, which will help will possible future clinical issues. In terms of a timeline, we are aiming to be towards the end of the programme in around a year from now. This has been agreed by the national team who will help with implementation. Funding has been agreed across Scotland by the Chief Medical Officer for a period of two years. Linking into the Genesis National Medical Equipment Management System will take place in September 2025 and we have a National Licence for the system that is being used. NMcC advised that he will continue sharing information with the group, adding that Janette Keenan sits on the National Group, where information will also be forthcoming. The group has two meetings prior to March 2025 when we will require to have reviewed our documentation and put in place improvements we feel are required. NMcC discussed an open question with the group regarding a dedicated Project Management team, asking if it would be made up of medical devices, PMO and digital to ensure the correct people were involved? Engagement with services is key including D&I, theatres, clinical teams and administrative staff is critical to ensure the project has the correct sponsorship. IMacL added benefits will include a resulting cost saving in terms of procurement, oversight of devices, less waste etc. He agreed that a group will be required to take this forward and recognition that there may be positive benefits once the programme is up and running. AG added that from a digital perspective, Scan for Safety has been tracked for some time now and was included in their Annual Delivery Plan response too.	

Unconfirmed

	He added that the more information governance part of this can be prepared in advance then the easier the pathway will be to getting the technology up and running. Making these devices secure on the network is an important element too alongside the implementation and there are other products being discussed nationally and will be introduced to boards to support this. MMcA added that following his visit to the Golden Jubilee Hospital, Clydebank and following a detailed run through of how the programme works there, it was his understanding that the system was owned and managed by Procurement as it links to the national Genesis system and operated by a stock control person in eg theatres. It was noted that the biggest change was trying to get staff on board and adapting to a digital way of working. MW added that the digital system will have benefits for the theatre team she mentioned business continuity if the scanners go down and implant registers linking up on a national level. NMcC added that hopefully, by September 2025, there will be several other boards we can link into in terms of implementation issues etc. He added that it was to be a Once for Scotland approach, however, confirmation will have to come from some of our clinicians in terms of meeting the requirements of the National Arthroplasty Register. Action - In terms of Procurement, KB was not aware of much discussion on the subject at the Regional Procurement Group and agreed to update the group at the next meeting in December 2024. NMcC thanked IF and his team for the work that is being carried out around the equipment database. Overall, the Scan for Safety Programme is about how we control and decide what medical equipment is brought into the organization, how we will look after the equipment, trace and ensure we understand where equipment is being used and on whom. Consideration is being given to the Five-Year Replacement Equipment Plan in terms of the best use of the resources we have.	**KB**
5 5.1	**<u>FOR INFORMATION</u>** <u>RFID Tagging</u> We have RFID tagging technology at the VHK which allows us to identify where any tagged equipment is, using active tags.	

Unconfirmed

	We have recently invested in a printer and labels for adding passive tags to equipment which will allow us to tag smaller less value items and by walking through a ward we can identify what equipment is located there.	
6 6.1 (a) (b) (c) (d) 6.2 (a)	**<u>MINUTES FOR NOTING</u>** **<u>Capital Equipment Management Group</u>** (CEMG) Copies of the Fife Capital Equipment Management Group minutes, noted below, were distributed to group members in advance of the meeting: CEMG Minute of 4 April 2024 CEMG Minute of 2 May 2024 (meeting cancelled) CEMG Minute of 6 June 2024 CEMG Minute of 19 June 2024 (additional meeting) There were no comments or questions raised on the CEMG minutes by the group. **<u>Point of Care Testing Committee</u>** (PoCTC) A copy of the Point of Care Testing Committee minute, noted below, was distributed to group members in advance of the meeting: PoCTC Minute of 5 June 2024	
7 7.1	**<u>ANY OTHER BUSINESS</u>** <u>Function of the Medical Devices Group</u> IMac was keen to re-affirm that the function of the group was to have strategic oversight to have the required policies and procedures in place to allow for medical devices to be organized within ie Medical Physics and other services and for it not to become a decision-making group on pieces of equipment. NMcC added that when a database in place, with an automated system we will benefit from being more efficient in terms of labour, enforcement of policies and be able to standardise pieces of equipment. If the MD Group focuses on the policies and direction of travel of medical devices, with the CEMG focusing on the replacement of equipment. Reviewing the ToR for the group will get us to exactly where this group sits and whether a Sub-Group will be required or to pull in resources from an existing group?	

Unconfirmed

7.2 7.3	The key is control and to avoid streams of new individual pieces of equipment coming into the organization by different people having different preferences to what they want. This is important too in terms of maintaining the equipment. He added that within NHS Fife, there are many maintenance contracts in existence and by streamlining these and making a decision on which can remain in-house and which can be out sourced will save the organization a considerable amount of money and be more efficient. Integration Works - Welsh Allen Monitors within Clinical Systems AG advised the group of the completion of the integration work in Wards 44 and 45 at VHK with the evaluation now concluded. The Clinical teams are inputting the observation information into patient track through the keyboard and the integration is showing an efficiency improvement of around 60 seconds per set of observations. This proves quite considerable in terms of what this means to these two board areas from a benefits perspective and in terms of future choices and our approach to the appropriate replacement of medical devices so these can be integrated over time. Action - Distribution of report to group members following the meeting for comment. Post Meeting Note - The Proof of Concept Evaluation Report was distributed to the group on 27.09.24. BD Care Fusion Equipment - Obsolete Licence IF advised that a BD Care Fusion obsolete licence was discussed at the last Capital Equipment Management Group meeting. Thereafter, it was highlighted that IF bring a paper to the Medical Devices Group meeting. MMcA added that he had the paper and was awaiting further output, however he agreed to forward to NMcC to agree on the most appropriate group to direct the paper to. Action - MMcA to take forward.	**AG** **AB for AG** **MMcA**
8	**DATE & TIME OF NEXT MEETING** Wednesday 11 December 2024 at 2 pm on Team	

Unconfirmed

MEDICAL AND DENTAL PROFESSIONAL STANDARDS OVERSIGHT GROUP (Meeting on 14 October 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 Monday, 14th October 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
Prof M Wood	Director of Medical Education
Dr M Philp	GP Appraisal Lead
Dr E O'Keefe	Director of Dentistry
Ms J Anderson	General Manager, Women, Children & Clinical Services
Dr I Banerjee	LNC Representative
Dr S Savage	Associate Director for Risk and Professional Standards
Dr J Tomlinson	Director of Public Health
Ms S Ali	Medical Education Manager
Ms G Couser	Associate Director of Quality and Clinical Governance
Ms A Gracey	Medical Appraisal and Revalidation Co-ordinator
Ms Lisa Cooper	Head of Primary and Preventative Care Services
Dr H Hellewell	Deputy Medical Director – Fife Health & Social Care Partnership
Dr S McCormack	Associate Medical Director – Surgical and Medical Directorate

Apologies:

Dr I MacLeod	Deputy Medical Director – NHS Fife Acute
Dr J Morrice	Associate Medical Director, Women and Children
Mr E Dunstan	Secondary Care Appraisal Lead
Dr J Pickles	LNC Representative

ACTION

1 Welcome/Apologies for absence

Apologies noted as above.

2 Draft Note of previous meeting (19/07/2024)

Minutes accepted by group as an accurate record. **DMc**

3 Action Tracker

Action: Item 2: Terms of Reference - Medical Education SLT minutes to be fed into this group. Further discussions into this with SA and GC to discuss what exactly is relevant to bring to this group from the Medical Education Committee side of things. It was confirmed that they would provide a flash report.
Status – Completed and Closed.

Action: Minutes and terms of reference to be shared with this group after their meeting has taken place – minute of last HSCP Workforce Planning meeting shared.
Status: Completed and closed.

Action: HH, IM, SMc, AK to discuss the need for the 3rd sign off' and any issues there may be excluding this - SMc Confirmed that the Surgical and Medical Directorates would keep the budget holder i.e. General Manager as 3rd sign off. HH advised they are keeping the current sign offs for now and will review for next year
Action: Ongoing

Action: HH to share flash report with SAS or AG - Template shared with AG.
Status: Completed and Closed.

4. **Medical Appraisal and Revalidation.**

AG reported that the priority for the service is to ensure that all doctors have access to an appraiser when their appraisal is due and noted that this is more challenging within Secondary Care due to the lack of appraisers.

AG advised that there will be 4 appraiser sessions available in Primary Care as of April due to retirement.t MP has successfully managed to recruit from within the current appraiser cohort to cover these sessions.

There is also a need to recruit to the Local Appraiser Advisor role next year as MP is one of the appraisers retiring at end March 2025.

AG reported that there were 58 revalidations during the last 3 months and 6 deferrals. The deferrals were due to lack of information (an example being the need to obtain patient feedback after maternity).

CM added that another reason for deferrals can be when Doctors rejoin or come from oversees. In these cases, the GMC often only give you a 2 year turn around for a revalidation date. This is for the RO to have close sight of their activity on their return to ensure there are no competency issues. In some of these cases though they do need to be deferred to have more time to gather the information required.

AG referred to the Medical Appraisal and Revalidation Annual Report 2023/24 tabled for information.

5. **Consultant and SAS Doctor Job Planning.**

SMc stated that job planning in the Medical and Surgical directorates is progressing and the majority of plans are in discussion. The report she ran gave the date the person was last on the system and the majority were in the last few months. This is a big improvement from previous years.

The Medical Directorate are hoping to have 80% signed off by December. A third of those in the Surgical Directorate still need further work but conversations are underway. It was noted that the Emergency Department has been struggling with the eJobplan and SMc assured the group that Ian Fairbairn and Melvin Carew have had a lot of discussion around activities in the Emergency Department as to whether these should be in the job plan or extra. Hopefully the hard work will soon be reflected in the numbers.

HH stated that there have been improvements within Primary, Preventative Care and Community portfolios. They have set out a plan for education and conversations for staff to help progress this, especially in Mental Health. There is continued monitoring in the Workforce Group meeting with eJobPlan being a standing item. This should ensure the pace of improvement continues.

AG confirmed that job plans are locked down at the end of January/beginning of February, allowing for a couple of months to review job plans before the start of the next year on 1 April 2025.

6. Medical Education.

MW reported that a lot of effort is being put into getting ready for ScotCom. There has been recruitment from various secondary care specialities on a short term basis to provide input to the curriculum development. The Hub 1 lead post which is a joint post with MoE is currently sitting in the VMF process.

MW advised that NES has confirmed that the Scottish Government will provide funding to develop Cedar House, Whyteman's Brae Hospital, for Student accommodation and that Medical Education has been given additional space for expansion within Victoria Hospital. MW also reported that The Education Hub at Cameron House has opened, which is an integral part of ScotCom.

MW reported that 5 Associate Directors of Medical Education have been appointed.

MW also reported that NHS Fife has been judged as excellent in some surgical specialties but unfortunately did not do so well in Medicine. She advised that there are ongoing discussions between NES and NHS Fife and a meeting planned. There are challenges in the number of senior trainees in Fife within some specialities particularly medicine, anaesthetics and in psychiatry.

MW also advised that they are working to achieve hot food 24/7 for all staff particularly those working overnight.

7. Dental Education.

Emma O'Keefe stated that they have got a good cohort of vocational trainees that have come into dental practises within Fife. There are 8 out of 12 possible posts in place.

Core training has started within the public dental service, a first for a good number of years. There is a bit of learning around the processes, particularly occupational health clearance with NES and NSS.

There has been really good feedback from outreach places for dental students. Emma O'keefe stated that there's a bit of underfunding from NES that comes into Fife Health Board and other health boards

We look to Dundee and Edinburgh Dental Institute for referrals to secondary tertiary care, but also get students and trainees on placement There is one general dental practitioner in Fife that's on the leadership fellowship this year. There are only two dentists in Scotland on that fellowship, so that's really positive for Fife.

EO advised that the challenge within Dental is that there is no revalidation process required by the GDC. It is recommended as part of the practise to have inspections around PDPs, but it is not a requirement. They do however have to do a certain amount of CPD hours and submit that annually.

8. Medical Workforce Planning – Acute Services.

SMc updated the group from the Medical staffing meeting.

Monitoring has been undertaken in the Medical and Surgical Directorates, with Women's and Children's happening shortly. Changes with the Medical Juniors has gone really well to date. There haven't been enough forms received to make it viable but the forms that have been returned have been the best yet in terms of taking breaks.

In terms of the Doctor in training wellbeing campaign, there wasn't an update from the PMO although the CD's had been asked to complete the escalation pathways within directorates for juniors not achieving breaks. This has now been done and the document is being put forward for publishing.

All 3 directorates are making progress with job planning; however getting the final sign off is taking time. SMc advised that they are pushing for completion before the end of the year.

Locum costs are down across all directorates and it is really much improved.

Study budgets for doctors to be brought to the next Medical Staffing meeting to ensure parity across directorates.

9. Medical Workforce Planning - HSCP

HH discussed their priority areas around the consultant vacancies. In terms of rheumatology, only 1 WTE substantive consultant will be in post after Nov 2024. Psychiatry locally and nationally continues to be a challenge.

Education is being planned for Mental Health to be able to engage fully in job planning.

Work is ongoing towards delivery of CSER Fellowship/Portfolio Programme in psychiatry. CM asked that more detail of the CSER fellowship be brought to the next meeting. HH agreed to bring a paper to the next meeting. **HH**

CM raised a concern that if we have a significant number of mental health trainees coming out at the one time, then there may be no jobs for them. HH advised that it is a rolling programme where the trainees move around different specialties then you can keep recruiting year on year but can stop recruitment once you have enough trainees. She felt it would be clearer once the paper was presented.

HH noted that there is still lack of interest in posts within rheumatology and the Sir George Sharps unit.

<u>Action</u>: HH to bring the paper the next meeting of the Portfolio Programme.

10. Any Other Competent Business

There was none

11. **Date, Time and Venue of Next Meeting – To be confirmed.**

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

INFECTION CONTROL COMMITTEE (Meeting on 1 October 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed)

1st October 2024 at 1400 via Teams

Item No	Subject	Actions
1	**Attendees** Nicola Robertson, Director of Nursing (Chair- deputising for Janette Keenan) **NR** 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** Julia Cook, Infection Control Manager **JC** Catherine Gilvear, Head of Quality, Clinical & Care Governance **CG** Mirka Barclay, Senior IPCN **MB** William Nixon, H&S Manager **WN** Suzanne Watson, Senior IPCN Care Homes **SuW** Paul Bishop, Assoc. Director of Estates **PB** Fiona Bellamy, Senior HPNS **FB** Sharon McDonald (Minutes) **SM**	
	Apologies Janette Keenan, David Griffith, Steven Wilson, Keith Morris, Priya Venkatesh, Norma Beveridge, Iain McLeod, Neil McCormick, Aileen Lawrie, Lynn Barker, Elizabeth Dunstan, Jamie Gunn NOTE- meeting not quorate as no Consultant Microbiologist in attendance. Agreed to continue meeting but any decision making actions would be carried forward to next meeting	
2	**Minute of Previous Meeting** Minutes of previous meeting were approved.	
3	**Action List** • (Pt. 11) JC to email SB for update on meeting re staff immunisation screen, prior to next meeting. • (Pt. 10) AM – paper has gone to SLTs for escalation to EDG (re isolation period) following discussions re EDG / National Guidance regarding COVID. Contact part of paper is live. NR will take to EDG on 3 Oct. 24. • (Pt. 7) AM to take to Pharmacy - issues about linking in with communications re CDI increase due to PPI. • (Pt. 5) JC has met with SMcG and RG – now waiting to get date fixed in diaries with lab managers. • (Pt. 4) JC has met with SP re pertussis boosters for staff every 5 years. Guidance has since been released. No OH representation at today's meeting. • CG raised issues with Lanquip and lack of InPhase or MEG system. NR added that InPhase should be in place by the end of the financial year. JC and NR to speak to Clin.Gov. colleagues re timeline for InPhase.	**JC** **AM** **AM** **JC** **JC/NR**
4	**Standing Items**	
4.1	**Risk Register** 3 high level 15 moderate level 1 low level	

	2 new risks from the HPT (3026 respiratory infections for vulnerable settings) & (3027 emergent infectious diseases) Reduction in 1 risk – water systems contamination Closed 3 risks – SAB LDP standard, ENT W5 complete, IPC workforce. 2 remain despite meeting targets – Legionella and Pseudomonas JC advised MORSE is yet to be added to the Risk Register.	**JC**
4.2	**<u>HAIRT Board Report</u>** LD gave overview of report. Up to end August 2024 Q1 ARHAI report • SAB – reduction in year ending totals. 5 PVC related SABs, CCR been done on each. No further dialysis line this year. 7 PWID related. • CDI – reduction in year ending totals. Slight increase in CA CDIs. PPI most common risk related. **<u>MRSA & CPE</u>** • NHS Fife compliance rates down for Q2. Met MRSA, CPE below target. A further review of the non-compliant cases identified a delay in submission to PatienTrak, but recorder on paper assessments. **<u>ECB</u>** Increase in total and HCAI. Reduction in CAUTIs. **<u>UCIG</u>** Group met in August. **<u>Domestics & Estates Monitoring</u>** Above targets- GREEN status. **<u>Outbreaks</u>** July & August 2024 • 3 GI • No flu outbreaks • 5 COVID-19 – no COVID related deaths. JC raised project bringing in electronic health records to be introduced in NHS Fife in Summer of 2025, will hopefully help with MDRO reporting. CG asked about trends/clusters that can be highlighted re CDI CO cases. Meeting to be arranged to discuss further.	**JC/PV/LD**
4.3	**<u>Care Home Update SW</u>** • Support following Care Inspectorate issues – walkabout and bespoke training. • Education – SCIPS, Winter Preparedness, Scabies protocol and awareness (192 staff and >16 homes) • Link Practitioner training 8 Care Homes completed, 1 to follow and 1 did not attend, which SW will follow up. • Working with Dermatology re scabies awareness and training with AMPs and GPs. • Routine visits – monthly contact, bi-monthly visits all on tract • Scabies Awareness training has been implemented in CH with very good uptake. MR raised cleaning spec to be updated at national level in CH – MR will chase.	**MR**
4.4	**<u>NHSS National Cleaning Services Specification</u>** • Report was discussed. • Results for NHS Fife remain stable. • Quarterly average is slightly higher for NHS Fife than NHS Scotland. • Peer and Public audits continue. • Annual Facilities Questionnaire Report was completed in June 2024 and been issued widely.	
4.5	**<u>Learning Summary</u>** Nothing to report. Discussion about how we want learning summaries presented at IPCC. Minutes from CCRs to be sent to IPCC. Themes being pulled from PAN Fife group. JC to have conversation with TL and JG. Anything to be shared with Organisational Learning Group.	**JC**
4.6	**<u>National Guidance</u>** AM reported updates: MPox Clade 1 review and update to national guidance.	

4.7	**Isolation & Risk Assessment** JC discussed SBAR around mental health and required Risk Assessment to be added to MORSE, as discussed earlier to be added to Risk Register as D&I have indicated likely not in place till next year.	
4.8	**Quality Improvement Programmes** **PWID & UCIG** CG – discussed MAT4 group meeting.	
4.9	**Education** AM reported: IPC Study days – went very well, received positive feedback. A further study day has been arranged to take place at QMH 31st October. Student Nurse training day in August 2024 in conjunction with University of Dundee and NHS Tayside. St Andrews year 3 medical student IPC/Wound Care module has commenced, in conjunction with tissue viability team. Increased HCID/PPE training in light of Mpox Clade 1 alerts. NQP sessions well attended. SCRIBE education provided at Glenrothes hospital with Estates, which has been requested further. JC raised AMR and IPC Specialist Career Development Frameworks are =being developed/under review by NES.	
4.10	**Infection Prevention & Control Audit Programme Update** JC reported: August 10 audits were carried out, with 5 re-audits. Discussion re collaborating with care assurance audit.	
4.11	**HAI-SCRIBE** AM highlighted: OOS location walkabouts continue. Refurb has started in renal dialysis at QMH. Pitcheucar HC refurb work starting in ~2 weeks.	
4.12	**Capital Planning** MB updated - MH project in QMH ward 3 refurb started August, will be mix of General Psychiatry and Older Adults Audiology booth work started in ENTHN. Phase 1 VHK, Cameron and RW work coming to an end.	
4.13	**HCAI Strategy** JC gave update. 2 year strategy, to provide foundations of the next 5 year IPC strategy 2025-2030. No updates, at present, from year 1. Will report further information following attendance at Working Together event at Golden Jubilee with CNOD on 2 October.	
4.14	**Infection Prevention and Control Annual Work Programme Update** JC reported ongoing challenges around AMR and AMR workforce. SSI Surveillance Programme remains paused. SLWG nationally.	
4.14	**Health Protection** Duncan F-W will attend the 4th December meeting, to receive SBAR update in advance.	**JC**
5	**New Business**	
5.1	**Incidents/Outbreaks/Triggers** AM reported, communication documented as positive experience between wards/units and IPC. A challenge noted around cleaning. HCW not always able to do their part to allow the domestic teams to do their work. Where concerns are raised, extra training has been given at the time and post closure. Pseudomonas – no further cases than initial 4. SCRIBE is completed, awaiting timeframe to start works to remove taps.	
5.2	**The IPC Workforce Strategy 2022-24** Nothing to update.	
5.3	**PAN NHS Fife IPC Group** AM advised, new group combines acute and HSPC governance group to feed up into ICC any themes, trends and concerns for escalation.	
5.4	**ICNET AND LIMS** ICNET and LIMS integration still not fully functioning. Coding has not been mapped fully. PoC testing locations has not been resolved. Remains on the risk register.	

	JC and NH to discuss separately.	**JC/NH**
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** Nil to raise.	
7	**Any Other Business**	
	JC discussed the ARHAI Scotland TBP literature review – now expected Spring 2025. Chapter 4 – DL re water safety – SLWG will need to be arranged to have in place for 1sy=t of January 2025 NHS Fife IPC won a silver IPS award for nurturing new IPC talent at the IPS Awards. CC added how useful she found the face to face training at the IPC study day.	
8	**Date of Next Meeting**	
	4th December 2024 at 2pm, via Teams.	