NHS Fife Clinical Governance Committee

Fri 01 March 2024, 10:00 - 12:50

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Arlene Wood

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Arlene Wood

10:00 - 10:00
0 min

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

Enclosed *Arlene Wood*

Item 3 - Clinical Governance Committee Minutes (unconfirmed) 20240112.pdf (10 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Arlene Wood*

Item 4 - Clinical Governance Committee Action List - 20240301.pdf (3 pages)

10:10 - 10:30
20 min

5. ACTIVE OR EMERGING ISSUES

5.1. Research & Development Progress Report & Strategy Review 2023-25

Enclosed *Dr Chris McKenna*

Item 5.1 - SBAR Research & Development Progress Report & Strategy Review 2023-25.pdf (4 pages)
Item 5.1 - Appendix 1 Research Strategy Priorities 2022-23.pdf (3 pages)
Item 5.1 - Appendix 2 Research, Innovation and Knowledge Strategy 2022-25.pdf (16 pages)

5.2. Research, Innovation and Knowledge Annual Report 2022/23

Enclosed *Dr Chris McKenna*

Item 5.2 - SBAR Research, Innovation and Knowledge Annual Report 2022-23.pdf (5 pages)

10:30 - 11:10
40 min

6. GOVERNANCE MATTERS

6.1. Clinical Governance Committee Self-Assessment Report 2023/24

Enclosed *Dr Gillian MacIntosh*

Item 6.1 - SBAR Clinical Governance Committee Self-Assessment Report 2023-24.pdf (14 pages)

6.2. Annual Review of Clinical Governance Committee Terms of Reference

Enclosed *Dr Gillian MacIntosh*

- Item 6.2 - SBAR Annual Review of Clinical Governance Committee Terms of Reference.pdf (6 pages)

6.3. Corporate Risks Aligned to Clinical Governance Committee, including Deep Dives: Optimal Clinical Outcomes

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

- Item 6.3 - SBAR Corporate Risks Aligned to the CGC.pdf (6 pages)
- Item 6.3 - Appendix 1 Corporate Risks Aligned to the CGC.pdf (9 pages)
- Item 6.3 - Appendix 2 Deep Dive Review Optimal Clinical Outcomes.pdf (5 pages)
- Item 6.3 - Appendix 3 Assurance Principles.pdf (1 pages)
- Item 6.3 - Appendix 4 Risk Matrix.pdf (2 pages)

6.4. Clinical Governance Oversight Group Assurance Summary from February 2024 Meeting

Enclosed *Dr Shirley-Anne Savage / Gemma Couser*

- Item 6.4 - Assurance Summary Clinical Governance Oversight Group February 2024.pdf (7 pages)

6.5. Final Annual Workplan 2024/25

Enclosed *Gemma Couser*

- Item 6.5 - Final Annual Workplan 2024-25.pdf (5 pages)

6.6. Delivery of Annual Workplan 2023/24

Enclosed *Dr Shirley-Anne Savage*

- Item 6.6 - Delivery of Annual Workplan 2023-24.pdf (8 pages)

11:10 - 11:45
35 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report

Enclosed *Dr Chris McKenna / Janette Keenan*

- Item 7.1 - SBAR Integrated Performance & Quality Report.pdf (4 pages)
- Item 7.1 - Appendix 1 Integrated Performance & Quality Report.pdf (16 pages)

7.2. Healthcare Associated Infection Report (HAIRT)

Enclosed *Janette Keenan*

- Item 7.2 - SBAR Healthcare Associated Infection Report.pdf (6 pages)
- Item 7.2 - Appendix 1 Healthcare Associated Infection Report.pdf (27 pages)

7.3. Alignment of NHS Fife Realistic Medicines / Value Based Health and Care Delivery Plan and the Scottish Government Value Based Health and Care Action Plan

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

- Item 7.3 - SBAR Realistic Medicines Value Based Health... + appendices 1 & 2.pdf (5 pages)
- Item 7.3 - Appendix 3 Realistic Medicine Value Based Health and Care Report (Flash Report).pdf (2 pages)
- Item 7.3 - Appendix 4 Realistic Medicine Value Based Health Care Delivery Plan.pdf (13 pages)

7.4. Safe Delivery of Care Inspection and Learning Review - Victoria Hospital from 31 July 2023 to 2 August 2023

Enclosed *Janette Keenan*

Item 7.4 - SBAR Safe Delivery of Care Inspection and Learning Review - Victoria Hospital.pdf (5 pages)

11:45 - 12:05
20 min

8. DIGITAL / INFORMATION

8.1. Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme

Enclosed *Dr Chris McKenna / Alistair Graham*

Item 8.1 - SBAR HEPMA Programme.pdf (4 pages)

8.2. Information Governance and Security Steering Group Update

Enclosed *Alistair Graham*

Item 8.2 - SBAR Information Governance and Security Steering Group Update.pdf (8 pages)
Item 8.2 - Appendix 1 IGS Accountability and Assurance Framework - Exec Summary.pdf (11 pages)

12:05 - 12:30
25 min

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1. Patient Story

Presentation *Janette Keenan*

9.2. Patient Experience & Feedback Quarter 3 Report

Enclosed *Janette Keenan*

Item 9.2 - SBAR Patient Experience and Feedback Report.pdf (4 pages)
Item 9.2 - Appendix 1 CGC Patient Experience Flashcard Q3.pdf (5 pages)
Item 9.2 - Appendix 2 Patient Experience & Feedback Quarter 3 Report.pdf (16 pages)

12:30 - 12:40
10 min

10. ANNUAL REPORTS / OTHER REPORTS

10.1. Medical Education Annual Report 2022/23

Enclosed *Dr Chris McKenna / Gemma Couser*

Item 10.1 - SBAR Medical Education Annual Report 2022-23.pdf (4 pages)
Item 10.1 - Appendix 1 Medical Education Annual Report 2022-23.pdf (10 pages)

10.2. Organisational Duty of Candour Annual Report 2022/23

Enclosed *Dr Chris McKenna*

Item 10.2 - SBAR Organisational Duty of Candour Annual Report 2022-23.pdf (4 pages)
Item 10.2 - Appendix 1 Organisational Duty of Candour Annual Report 2022-23.pdf (21 pages)

12:40 - 12:45
5 min

11. LINKED COMMITTEE MINUTES

11.1. Area Clinical Forum held on 8 February 2024 (unconfirmed)

Enclosed

Item 11.1 - Linked Minute Cover Paper.pdf (1 pages)
Item 11.1 - Area Clinical Forum Minutes (unconfirmed) 20240208.pdf (4 pages)

11.2. Area Medical Committee held on 12 December 2023 (confirmed)

Enclosed

- Item 11.2 - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.2 - Area Medical Committee Minutes (confirmed) 20231212.pdf (9 pages)

11.3. Cancer Governance & Strategy Group held on 11 January 2024 (unconfirmed)

Enclosed

- Item 11.3 - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.3 - Cancer Governance & Strategy Group Minutes (unconfirmed) 20240111.pdf (14 pages)

11.4. Clinical Governance Oversight Group held on 13 February 2024 (unconfirmed)

Enclosed

- Item 11.4 - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.4 - Clinical Governance Oversight Group Minutes (unconfirmed) 20240213.pdf (14 pages)

11.5. Fife Area Drugs & Therapeutic Committee held on 20 December 2023 (confirmed) & 7 February 2024 (unconfirmed)

- Item 11.5i - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.5i - Fife Area Drugs & Therapeutic Committee Minutes (confirmed) 20231220.pdf (9 pages)
- Item 11.5ii - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.5ii - Fife Area Drugs & Therapeutic Committee Minutes (unconfirmed) 20240207.pdf (6 pages)

11.6. Fife IJB Quality & Communities Committee held on 17 January 2024 (unconfirmed)

Enclosed

- Item 11.6 - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.6 - Fife IJB Quality & Communities Committee (unconfirmed) 20240117.pdf (10 pages)

11.7. Resilience Forum held on 7 December 2023 (unconfirmed)

Enclosed

- Item 11.7 - Linked Minute Cover Paper.pdf (1 pages)
- Item 11.7 - Resilience Forum Minutes (unconfirmed) 20231207.pdf (6 pages)

12:45 - 12:50
5 min

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

12.1. To the Board in the IPQR Summary

Verbal

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

Verbal

12:50 - 12:50
0 min

13. ANY OTHER BUSINESS

12:50 - 12:50
0 min

14. DATE OF NEXT MEETING - FRIDAY 3 MAY 2024 FROM 10AM - 1PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

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

Present:
Arlene Wood, Non-Executive Member (Chair)
Colin Grieve, Non-Executive Member
Anne Haston, Non-Executive Member
Aileen Lawrie, Area Clinical Forum Representative
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Lynne Parsons, Area Partnership Forum Representative
Carol Potter, Chief Executive
Joy Tomlinson, Director of Public Health

In Attendance:
Nicky Connor, Director of Health & Social Care
Claire Dobson, Director of Acute Services
Peter Donaldson, Information Security Manager *(for item 6.2)*
Fiona Forrest, Deputy Director of Pharmacy *(deputising for Ben Hannan)*
Susan Fraser, Associate Director of Planning & Performance *(for item 7.1)*
Helen Hellewell, Deputy Medical Director, Health & Social Care Partnership
Jocelyn Lyall, Chief Internal Auditor *(for item 6.1)*
Tanya Lonergan, Head of Nursing *(deputising for Lynn Barker)*
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Elizabeth Muir, Clinical Effectiveness Manager
Gill Ogden, Head of Nursing *(deputising for Norma Beveridge)*
Nicola Robertson, Associate Director of Nursing
Dr Shirley-Anne Savage, Associate Director of Quality & Clinical Governance

The minutes were produced from the recording of the meeting, by Hazel Thomson, Board Committee Support Officer, who was not in attendance at the Committee itself.

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

A welcome was extended to Lynne Parsons, Employee Director, who is joining the Committee as the new Area Partnership Forum representative; Fiona Forrest, Deputy Director of Pharmacy, who is deputising for Ben Hannan; Tanya Lonergan, Head of Nursing, who is deputising for Lynn Barker; Gill Ogden, Head of Nursing, who is deputising for Norma Beveridge; Jocelyn Lyall, Chief Internal Auditor, who joined the meeting to speak to item 6.1 – Internal Control Evaluation on behalf of Margo McGurk; and Peter Donaldson, Information Security Manager, who joined the meeting to speak to item 6.2 – Cyber Resilience Deep Dive, on behalf of Alistair Graham.

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 member Sinead Braiden (Non-Executive Member), Kirstie MacDonald (Non-Executive Whistleblowing Champion) and routine attendees Lynn Barker (Associate Director of Nursing), Norma Beveridge (Associate Director of Nursing), Alistair Graham (Associate Director of Digital & Information), Ben Hannan (Director of Pharmacy & Medicines), Dr Iain MacLeod (Deputy Medical Director, Acute Services Division) and Margo McGurk (Director of Finance & Strategy).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 3 November 2023

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

4. Matters Arising / Action List

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

The Chief Executive provided an update for action no. 1, concerning 'the work being undertaken in relation to reviewing the effectiveness of the Organisational Learning Group'. Clarification was provided that the Chief Executive had not requested a formal review of the Organisational Learning Group and was questioning the approach to receiving and improving the managerial assurance from the group. It was therefore agreed to close this action from a committee perspective, as there is no commissioned formal review.

In terms of action no. 2, comments section, it was clarified that it is the 'Adverse Events Lead', and not the 'Adverse Manager', who is taking forward this action.

The Chair and Medical Director agreed to have a discussion outwith the meeting in relation to the level of detail required for the Committee to take assurance on the learnings that are happening from Adverse Events. It was agreed to close this action.

Action: Medical Director

The updates will be made to the action list.

Action: Board Committee Support Officer

5. ACTIVE OR EMERGING ISSUES

5.1 Reinforced Autoclaved Aerated Concrete (RAAC)

Assurance was provided from the Director of Property & Asset Management that a national drive is underway to identify reinforced autoclaved aerated concrete within all NHS Scotland estates. It was advised that the NHS Fife Health & Safety Team

have been investigating reinforced autoclaved aerated concrete on our sites and have identified 26 potential blocks (elements of buildings) within our estate that have been passed to the National Programme for further assessment. An overview was provided on the mitigations that have been put place to protect staff, patients and visitors. It was also noted that longer term this work will form part of the Scottish Government programme of redress.

Questions were welcomed and an explanation was provided on the process and phases of work for deteriorating areas, including risk assessments, reporting, and relocating staff and patients. The Director of Property & Asset Management agreed to consider building this into standard business continuity plans.

Action: Director of Property & Asset Management

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

5.2 Notification to Health & Safety Executive (HSE) of Work in Atmosphere Containing Radon

The Medical Director provided background detail on assessing Radon within the workplace, and advised that, in an area within Kinghorn Medical Practice, the level had just exceeded the Health & Safety Executive (HSE) requirement. It was reported that remedial work is being undertaken and it is expected that this will be fully addressed at the next levels check. It was also noted that the affected area is not used on a daily basis by staff or patients within the Practice. Comment was made in relation to the ability of staff feeling comfortable in reporting concerns, and assurance was provided that the issues were swiftly addressed and an alternative space to work was offered.

Confirmation was provided that ventilation systems will be reviewed in other sites, and the Director of Property & Asset Management agreed to confirm that ventilation systems are checked on a regular basis.

Action: Director of Property & Asset Management

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

6. GOVERNANCE MATTERS

6.1 Internal Controls Evaluation Report 2022/23

The Chair welcomed the Chief Internal Auditor to the meeting, who introduced and spoke to the report. It was advised that the report contains a full review of all areas of governance and provides early warning of any issues that may impact the Governance Statement and would need to be addressed before year-end. The report sits alongside the Annual Report and standalone audits.

An overview of the key themes from the report was provided, as detailed in the paper, and it was highlighted that the environment is challenging in terms of delivering the strategy. Assurance was provided that previous internal audit recommendations for clinical governance arrangements have all been implemented, which was a positive outcome.

It was confirmed that the Health Improvement Scotland Inspection Report and learning review will go the March Committee meeting. Furthermore, it was stated that the Committee will continue to improve, carry out due diligence, and that the hard work of the Committee is recognised within the report. The Chair noted a number of actions around the Digital and Information Strategy, Inspection reports, and ICO incidents for disclosure for the Committee within the report and requested that this was reviewed and added to the Committee workplan to ensure that these are completed by year end.

Action: Associate Director of Quality & Clinical Governance

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

6.2 Corporate Risks Aligned to Clinical Governance Committee, including Deep Dives: Covid-19 and Cyber Resilience

The Chair welcomed the Information Security Manager to the meeting, for discussion on the deep dive.

The Medical Director reported that an update on optimal clinical outcomes, and adjustments to the quality & safety risk, will come to the March Committee meeting. It was also reported that a future risk is in development around wider threats such as pandemics and other biological incidents, and this will also come to the March Committee meeting.

The Associate Director of Quality & Clinical Governance provided an update on moving the corporate risk register forward, which will include consideration on capturing operational risks in order to escalate these to Board level. An update was also provided on the role of the Risk & Opportunities Group in terms of new risks and risks to be removed and the new approach to deep dives, which was also discussed at the last Audit & Risk Committee meeting. It was advised that a risk management framework has been developed, which will also support a culture of risk and will be promoted through the Risk & Opportunities Group.

The Committee took a **"reasonable" 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.

The Director of Public Health reported that the Covid-19 risk has achieved the risk target and that there has been a period of stability with reviewing this risk for a number of months. The main points from the paper were highlighted. It was also noted that other NHS Scotland Health Boards may follow a similar direction for de-escalating the Covid-19 risk.

The Committee took **assurance** on the Deep Dive and **agreed** on the recommendation to close the Covid-19 Pandemic risk on the Corporate Risk Register and transfer oversight to the Public Health Assurance Committee.

The Medical Director advised that the Cyber Resilience Deep Dive articulates the actions being undertaken to mitigate the risk of the organisation being overcome by targeted and sustained cyber-attacks, which could impact the ability to deliver a full health service. It was noted that there are aspects that are outwith NHS Fife's control, such as cloud services, which are hosted by other Health Boards and

National Services Scotland (NSS), and it was advised that improvement work with them is being undertaken.

The Information Security Manager provided an update on the work being undertaken to protect NHS Fife from cyber-attacks, as detailed in the paper. It was advised that the work is reported through the Information Governance & Security Group, who report directly into the Committee and the Digital & Information Board.

Questions followed, and it was reported that there are challenges in terms of recruitment and retention into digital roles. It was also reported that the reduced likelihood of the impact of the risk is through having good business continuity and disaster recovery options.

The Area Partnership Forum Representative requested that a staff-side representative be added to the policy group and that was agreed to be explored.

Action: Associate Director of Digital & Information

The Committee took **assurance** from the Cyber Resilience Deep Dive.

6.3 Clinical Governance Oversight Group Assurance Summary from October & December 2023 Meetings

The Associate Director of Quality & Clinical Governance advised that the assurance summaries are presented to the Committee, following an audit recommendation. It was advised that the mortality report in hospital acquired Covid-19 cases will come to the March Committee meeting. It was also advised that the independent review of audiology will be brought to the Committee in due course.

The Associate Director of Quality & Clinical Governance agreed to consider strengthening the assurance aspects of the report, particularly around how assured the Clinical Governance Oversight Group are around actions, planned improvements and timescales.

Action: Associate Director of Quality & Clinical Governance

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

6.4 Review of Draft Annual Workplan 2024/25

The Medical Director and Associate Director of Quality & Clinical Governance agreed to consider the points raised in an email from the Chair in relation to specific items on the workplan.

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

The Committee considered and **approved** the proposed workplan for 2024/25; and **approved** the approach to ensure that the workplan remains current.

6.5 Delivery of Annual Workplan 2023/24

The Health Improvement Scotland Report and learning review, and the future risk, which is in development around wider threats such as pandemics and other biological incidents, agreed to be added to the workplan for March 2024.

Action: Board Committee Support Officer

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

7 STRATEGY / PLANNING

7.1 Population Health & Wellbeing Strategy Mid-Year Review

The Associate Director of Planning & Performance joined the meeting for this item and advised that the report details the progress on the implementation of the organisational strategy, and the key points from the report was provided. An overview was also provided on the planned next steps.

A comment was made around minimising and avoiding repetitive work for staff in reporting of data, and it was advised that timelines for the Mid-Year Report differ from the Annual Delivery Plan, and that work is planned through the Programme Board to align timescales and various reporting schedules, including reporting to the Scottish Government. Suggestion was made to have a workplan. The importance of the Mid-Year report being presented to the Committee was highlighted.

The Committee took **assurance** from the mid-year report and the first six months of work to implement the NHS Fife Population Health & Wellbeing Strategy.

7.2 Medical Appraisal and Revalidation Framework 2024-27

The Medical Director explained that the aim of the Medical Appraisal and Revalidation Framework is to set out our plans to deliver high level appraisal and continue to train appraisers, which was noted as challenging, particularly within secondary care. It was also advised that the framework will ensure that every single member of permanent and employed medical staff in Fife have access to the annual appraisal. It was noted that this does not include junior doctors, as they are assessed through their training programme, however, they will still be re-validated.

An overview on the key points from the framework was provided, and it was confirmed that the framework has been through the Medical Appraisal Revalidation Group.

Following questions, an explanation was provided around the process for doctors being re-validated and it was advised that multi-sourced feedback is provided from NHS Education for Scotland (NES). The approach for supporting doctors to revalidate was also explained.

The Committee took **assurance** from the Medical Appraisal and Revalidation Framework 2024-27.

8 QUALITY/PERFORMANCE

8.1 Integrated Performance and Quality Report (IPQR)

The Director of Nursing provided an update on the performance for in-patient falls and the improvement work that is ongoing, including shared learning and the educational aspects. An update was also provided on performance for infection control.

The performance for pressure ulcers was discussed, with it being noted that performance was significantly higher in October 2023 and that a review is being carried out. It was advised that levels have now returned to normal, and the work that is being carried out to improve the performance for pressure ulcers was fully explained. Further detail, for assurance, was requested around pressure ulcers, in terms of providing additional information in the IPQR with breakdown of grades of pressure ulcer damage similar to the falls charts to support understanding of the severity of harm. The Director of Nursing agreed to take this forward.

Action: Director of Nursing

It was reported that work continues to improve our closure of actions in relation to adverse events, and that actions are specific, measurable, achievable, relevant and timebound (SMART).

The Committee took **assurance** and examined and considered the NHS Fife performance as summarised in the IPQR.

8.2 Healthcare Associated Infection Report (HAIRT)

The Director of Nursing spoke to the report and advised that there are no areas of concern to highlight to the Committee.

The Director of Nursing agreed to provide further information to the Chair around the detail on Covid-19 mortality.

Action: Director of Nursing

Following questions, it was advised that the performance target for CDI is on track, and that the numbers for C-Diff are very small. It was also reported that LanQIP is being used to record hand hygiene, and that infection control audits are carried out.

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

9. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

9.1 Patient Story

The Director of Nursing presented a patient story, which was focused on the complexities of the cancer care journey.

Following discussion, it was advised that the approach of staff can positively support cancer patients' feelings throughout their journey. It was also confirmed that the oncology team receive clinical supervision, and that the spiritual care team work closely with staff who are delivering cancer care.

The Committee took **assurance** from the presentation and the experience for both staff and patients on the cancer care journey.

9.2 Patient Experience & Feedback Report

The Director of Nursing highlighted the complexity scoring tool, which is currently being launched. An overview on performance was provided, as detailed in the

paper, The patient experience flashcard was also highlighted, which is provided as an appendix, and a request was made for the flashcard to cover the same reporting period. It was advised that work is underway to address aspects of the category of complaints, including staff attitude and disagreement treatment. A comment was made in relation to capturing the detail around complaints escalated to the Scottish Public Services Ombudsman (SPSO) including the detail regarding their status, themes and progress against recommendations and actions. One of the outcomes from the new complexity scoring tool will include that monitoring.

It was advised that a brief summary from the SPSO is provided within the Patient Experience & Feedback Quarterly Reports, with the next quarterly report to be presented to the Committee in March 2024.

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

10. ANNUAL REPORTS / OTHER REPORTS

10.1 Medical Appraisal and Revalidation Annual Report 2022/23

The Medical Director explained that the number of doctors who had an appraisal under secondary care is affected by the turnover of staff within that group, and that a large number were not eligible for appraisal. The Medical Director agreed to provide narrative around performance for revalidation, in the next report.

Action: Medical Director

Following a question, an explanation was provided on the doctors who did not revalidate, when eligible to do so, and is detailed in the report.

It was advised that the report was also presented to the Staff Governance Committee, where there had been good discussion on its conclusions.

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

10.2 Participation & Engagement Annual Report 2022/23

The Director of Nursing advised that the report is presented to provide assurance on the public engagement and consultation work undertaken in 2022/23. It was further advised that a Public Participation & Community Engagement Strategy is being developed by Corporate Communications and will include the outcomes and plans from the Health Improvement Scotland (HIS) self-assessment.

The Committee took **assurance** from the report and **noted** future steps.

10.3 Research & Development Progress Report & Strategy Review 2023-25

The Committee **noted** the report, and it was **agreed** to bring this item back to the Committee in March 2024, for assurance, under the active/emerging section. A request was made for questions or comments to be sent in advance to the Medical Director.

Action: Members/Medical Director/Board Committee Support Officer

10.4 Research, Innovation and Knowledge Annual Report 2022/23

The Committee **noted** the report, and it was **agreed** to bring this item back to the Committee in March 2024, for assurance, under the active/emerging section. A request was made for questions or comments to be sent in advance to the Medical Director.

Action: Members/Medical Director/Board Committee Support Officer

11. LINKED COMMITTEE MINUTES

The Committee **noted** the linked committee minutes and that there were no escalations to the Committee other than Health and Safety Subcommittee covered on the agenda today.

11.1 Area Clinical Forum held on 7 December 2023 (unconfirmed)

11.2 Area Medical Committee held on 10 October 2023 (unconfirmed)

11.3 Area Radiation Protection Committee held on 14 November 2023 (unconfirmed)

11.4 Cancer Governance & Strategy Group held on 2 November 2023 (unconfirmed)

11.5 Clinical Governance Oversight Group held on 24 October 2023 (confirmed) & 12 December 2023 (unconfirmed)

11.6 Digital & Information Board held on 19 October 2023 (unconfirmed)

11.7 Fife IJB Quality & Communities Committee held on 2 November 2023 (unconfirmed)

11.8 Health & Safety Subcommittee held on 8 December 2023 (unconfirmed)

11.9 Infection Control Committee held on 6 December 2023 (unconfirmed)

11.10 Information Governance & Security Steering Group held on 10 October 2023 (unconfirmed)

11.11 Research, Innovation & Knowledge Oversight Group held on 11 December 2023 (unconfirmed)

11.12 Resilience Forum held on 10 October 2023 (confirmed)

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 the Board.

13. ANY OTHER BUSINESS

There was no other business.

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

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST

Meeting Date: Friday 1 March 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	12/01/24	**Reinforced Autoclaved Aerated Concrete (RAAC)**	To build into standard business continuity plans, the process and phases of work for deteriorating areas, including risk assessments, reporting, and relocating staff and patients.	**NM**	June 2024	Risk assessments and all identified actions for mitigation have all been completed for those areas which have identifiable RAAC. The Director of Property & Asset Management is identifying how to build these into standard business continuity plans with the Head of Resilience.	Deadline not reached
2.	12/01/24	**Medical Appraisal and Revalidation Annual Report 2022/23**	To provide narrative around performance for revalidation, in the next report.	**CM**	November 2024		Deadline not reached
3.	12/01/24	**Corporate Risks Aligned to CGC, including Deep Dives: Covid-19 and Cyber Resilience**	To explore the option of adding a staff-side representative to the digital policy group.	**AG**	March 2024	Staff-side will have an opportunity to consider via the General Policies Group and in advance of presentation to EDG. ***Employee Director to confirm that this action can be closed.***	TBC - Closed
4.	12/01/24	**Healthcare Associated Infection Report**	To provide further information to the Chair around the detail on Covid-19 mortality.	**JK**	March 2024	Number reported in HAIRT is derived from information on Medical Certification Cause of Death (MCCD).	Closed
5.	12/01/24	**IPQR**	To provide further detail, for assurance, on pressure ulcers, in terms of providing additional information in the IPQR with breakdown of grades of pressure ulcer damage similar to the falls charts to support understanding of the severity of harm.	**JK**	March 2024	Complete.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
6.	03/11/23	**Patient Experience & Feedback Report**	To provide further detail on shared learnings in the next quarterly report.	**JK**	March 2024	On agenda. The report (Q3) covers Oct – Dec 2023 and provides the requested information.	Closed
7.	08/09/23	**IPQR**	Consideration to be given to the actions required to improve the key deliverable risk ratings, metrics and to expanding the narrative on any organisational learnings, in terms of closure rates, improvements and actions for Significant Adverse Events Review (SAER).	**CM/GC/ C Fulton**	March 2024	IPQR narrative continues to reflect the successes and challenges in managing adverse events. Specific focus is on learning from the current SAER process and outlining of improvements required, and actions that will be taken to ensure there is a consistently robust approach to identifying and learning from adverse events.	Closed
8.	12/01/24	**Delivery of Annual Workplan 2023/24**	To add to the workplan for March 2024, the Health Improvement Scotland Report and learning review, and the future risk, which is in development around wider threats such as pandemics and other biological incidents.	**HT**	January 2024	Deep dive on wider threats has been deferred to May 2024. Workplan updated. HIS report on agenda for 1 March 2024.	Closed
9.	03/11/23	**Clinical Governance & Strategic Framework Delivery Plan 2023/24 – Mid-Year Report**	To provide an update around the work being undertaken in relation to reviewing the effectiveness of the Organisational Learning Group.	**CP**	On hold	A verbal update was provided at the meeting and agreed to close action.	Closed
10.	12/01/24	**Research & Development Progress Report & Strategy Review 2023-25** **Research, Innovation and Knowledge Annual Report 2022/23**	To bring both items back to the Committee in March 2024, for assurance, under the active/emerging section. Questions or comments to be sent in advance to the Medical Director.	**CM** **Members**	February 2024	On agenda.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
11.	12/01/24	**Review of Draft Annual Workplan 2024/25**	To consider the points raised in an email from the Chair in relation to specific items on the workplan.	**CM/SAS**	March 2024	Complete. Response sent to the Chair.	Closed
12.	12/01/24	**Adverse Events**	To have a discussion with AW in relation to the level of detail required for the Committee to take assurance on the learnings that are happening from Adverse Events.	**CM**	March 2024	The Chair and CM are meeting on 27/02/24.	Closed
13.	03/11/23	**Annual Delivery Plan Quarterly Performance Report 2023/24**	The status for the deliverable for Hospital Pharmacy Redesign to be updated in the next iteration of the report.	**BH**	March 2024		Closed
14.	12/01/24	**Internal Controls Evaluation Report 2022/23**	To review the actions within the report around the Digital and Information Strategy, Inspection reports, and ICO incidents, and add to the Committee workplan to ensure that these are completed by year end.	**SAS**	March 2024	This has been reviewed with the Chair and the Medical Director and agreement reached on additions as required for the workplan.	Closed
15.	12/01/24	**Clinical Governance Oversight Group Assurance Summary**	To consider strengthening the assurance aspects of the report, particularly around how assured the Clinical Governance Oversight Group are around actions, planned improvements and timescales.	**SAS**	March 2024	This has been taken on board for the assurance summaries and will be strengthened during 2024/25 updates.	Closed

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Research & Development Progress Report & Strategy Review 2023-25**
Responsible Executive:	**Dr Christopher McKenna, Medical Director and Executive Lead RIK**
Report Author:	**Professor Frances Quirk, Assistant Director Research, Innovation and Knowledge**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Research and Development Review of Strategic Priorities 2022-2023 and the refreshed Research, Innovation and Knowledge (RIK) Strategy 2022-2025 are being brought to the Clinical Governance Committee for their Awareness to provide an update on activities against 2021-2022.

2.2 Background

This Review details the activities aligned to the 2022-2023 Strategic Priorities within RIK across NHS Fife from April 2022 to March 2023. The RIK Strategy documents the refreshed strategies to address direction and priorities for 2022-2025. The RIK strategy will support NHS Fife's overall strategic aim to provide the highest quality care to, and improve the health of, the population of Fife, within the resources available and in partnership with its staff, community planning partner organisations and the citizens of Fife. The RIK Strategy will support this by:

- promoting a culture that supports and encourages research and innovation as part of routine practice;

- building on the opportunities to work closely with academic and community planning partners to increase the volume and quality of research and innovation;

- promoting research and innovation within an appropriate governance framework;

- developing research and innovation knowledge and skills of staff and appropriate independent contractors;

- working in partnership with the citizens of Fife to ensure that research and innovation is patient-centered;

- aligning activity and priorities with the Population Health and Wellbeing Strategy and the Boards ambition to transition to Teaching/University Hospital status.

  Effective completion of activities supporting these priorities will better position NHS Fife to: seriously address the research and innovation agenda; compete successfully in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

2.3 Assessment

Notwithstanding significant achievements it is recognised that there is still scope to increase the research and innovation capacity and capability within NHS Fife. The outcomes of the Research Capacity and Culture Survey identified the main barriers to research are; a lack of protected time and/or dedicated funds for research, a lack of peer group support, lack of training in research skills and a perceived lack of the relevance / importance of research.

Every NHS organisation requires an appropriate balance of service delivery, research and learning in order to deliver the healthcare needs of the population. NHS Fife is predominately involved with service delivery supported by lifelong learning. Taking account of future demographic, social and technological change NHS Fife must increase the emphasis placed on research and innovation activity in order to support the delivery of the local health plan, the Annual Delivery Plan, the Population Health and Wellbeing Strategy and the national research and innovation agenda into the future.

2.3.1 Quality, Patient and Value-Based Health & Care

Clinical research and innovation inform the development of better outcomes in healthcare. New knowledge gained through clinical research and innovation results in improved methods of disease detection, prevention, diagnosis and treatment.

The benefits of clinical research and innovation are not only limited to patients who receive better health journeys as a result of their participation in clinical studies and innovation projects. Studies show that research and innovation active hospitals have improved

outcomes for all patients, not just study participants, research and innovation engagement also improves staff recruitment and retention through improved job satisfaction.

2.3.2 Workforce

The ongoing recovery from a focus on COVID studies alongside restarting suspended studies placed strain on staff's ability to adequately service restarted non-COVID studies and has had implications for capacity to participate in eligibly funded studies. This may have implications for future budget allocations. Reaching capacity will impact on meeting priorities related to increasing the number of studies, recruitment numbers and CSO budget allocations.

2.3.3 Financial

NHS Fife's annual research budget allocation of Support Funding from CSO (Chief Scientist's Office) was £830,000 in 2022-23, this was increased to £845,000 with an additional £15,000 uplift to cover the 7.5% pay award. These monies are provided for research considered eligible for funding, in recognition of the costs incurred by the NHS of undertaking and participating in such projects. This is currently the main source of funding available to support research in NHS Fife. Additional funding can be secured by increasing the number of eligibly funded projects undertaken by an NHS organisation, increasing the number of NHS Fife Chief Investigators and the recruitment into such studies. Additionally, commercial research and a small number of specific grant funded projects undertaken across NHS Fife also provide funding to support key staff to be employed to enable the research to be undertaken. Commercial research does not attract support funding from CSO since all costs to the NHS of participating in such activities must be met in full by the participating companies. Income from commercial recruitment activity during 2021-22 was £107,000 (compared with £77,000 in 2021-2022 and £135,603 in 2020-2021).

2.3.4 Risk Assessment / Management

Research, Innovation and Knowledge Oversight Group has noted the changes in the number of staff involved in research and commercial and non-commercial income generated over the reporting period. These KPI's will be a focus of monitoring and the development of strategies to address them in 2023-2024. A strategy to support and develop growth in Chief and Principal Investigators has been developed and is being implemented.

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

-

2.3.6 Climate Emergency & Sustainability Impact

-

2.3.7 Communication, involvement, engagement and consultation

Communication is the lynchpin of creating a research and innovation focused culture. During 2022-2023 regular NHS Fife Research and Innovation Newsletters and Bulletins were delivered, a monthly Publications Bulletin was circulated. Relevant updates, funding opportunities and education and training was circulated on StaffLink. The Publications

Bulletin and R&D weekly updates have been made available as outward facing to facilitate knowledge sharing and foster opportunities for collaboration. The NHS Fife Research Annual Report 2022-2023 has been produced and will be disseminated with stakeholders and research education and training was provided for NHS Fife staff and others.

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.

- Research, Innovation and Knowledge Operational Group – papers reviewed by circulation, feedback requested and responded to, where relevant (1st November 2023)
- Fife Community Advisory Council – papers reviewed and feedback requested (December 2023)
- Research, Innovation and Knowledge Oversight Group – papers reviewed, feedback requested and responded to (11th December 2023)
- Executive Directors Group- for Awareness (4th January 2024)

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Research Strategy Priorities 2022-2023
- Appendix No 2 Research, Innovation and Knowledge Strategy 2022-2025

Report Contact
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OUTCOME OF ACTIVITIES AGAINST RIK STRATEGIC PRIORITIES 2022-2023

The following plan of activities has been developed from the 2022-2025 NHS Fife Research Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research and innovation agenda; successfully compete in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION.

Investment in new clinical posts (medical, pharmacy, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers with identified and protected research time.

	OUTCOME
A1. To continue to encourage discussion of research as part of normal Personal Development Plans and appraisals of health care staff.	**ONGOING**
A2. To continue RIK participation in the development of the medical, pharmacy, allied health professions and nursing clinical academic career development in Fife.	**ONGOING**
A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.	**ONGOING**

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

	OUTCOME
B1. Identify and understand corporate arrangements with institutions such as St Andrews, Edinburgh, Dundee, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.	**ONGOING**
B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research active individuals, employed/seconded by NHS Fife and/or universities to build research capacity and governance structures.	**ONGOING**

(C) PROMOTING RESEARCH AND INNOVATION WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

In consolidating the research and innovation governance structures the current areas that need to be considered include:	**OUTCOME**
C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, information and educational governance structures within NHS Fife.	**ACHIEVED**
C2. Preparing for a potential inspection from Medicines and Healthcare products Regulatory Agency.	**ONGOING**
Increasing the income generated from increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:	
C3. Maximising commercial and non-commercial research opportunities locally and in collaboration on with external partners.	**ONGOING**

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH AND INNOVATION INFORMATION ACROSS NHS FIFE.

Consolidate a research and innovation communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research and innovation focused culture. During 2022-23 we will:

	OUTCOME
D1. Deliver a regular NHS Fife Research Newsletter.	**ACHIEVED**
D2. Produce and disseminate an NHS Fife Research Annual Report.	**ACHIEVED**
D3. Provide research workshops for patients, carers and other citizens of Fife	**ACHIEVED**

(E) PATIENT AND PUBLIC INVOLVEMENT

	OUTCOME
E1. Develop meaningful engagement of the public in research and innovation	**ACHIEVED**

Professor Frances Quirk
Assistant RIK Director, NHS Fife

December 2023

Progress against these priorities has been discussed and agreed by the NHS Fife RIK Operational Group and the NHS Fife Research, Innovation and Knowledge Oversight Group.

RESEARCH, INNOVATION & KNOWLEDGE STRATEGY 2022-25

Greater knowledge
Better services …

Last review date: **November 2023**

Next Formal Review: **August 2024**

Implementation Date: **December 2023**

Authors: **Prof Frances Quirk, Assistant Research, Innovation and Knowledge Director, NHS Fife Research, Innovation and Knowledge Leadership Team**

Submission Plan	Date
NHS Fife Research Innovation and Knowledge Operational Group	1st November 2023 (by circulation)
NHS Fife Research Innovation and Knowledge Oversight Group	11th December 2023
NHS Fife Clinical Governance Committee	12th January 2024
Executive Directors Group	18th January 2024

1. INTRODUCTION

1.1 NHS Research Scotland (NRS) via the Chief Scientist Office (CSO) has highlighted the need for the NHS to be an innovative and research-active environment, to ensure that good ideas are translated into wider practice and that ideas with commercial potential are identified and promoted.

1.2 The Scottish Government Health Department (SGHD) is committed to increasing the level of high quality research conducted in Scotland for the health and financial benefits of our population, so we are recognised globally as a leader in health science (Delivering Innovation through Research – Scottish Government Health and Social Care Research Strategy, 2015, UK Vision for Clinical Research Delivery and Implementation Plan). Both the SGHD and the UK Vision for Clinical Research strategies highlight what needs to be done, detailing the areas where we can and should make a difference and the need to increase the scope, relevance and quality of research to meet the health and healthcare needs of the people of Scotland.

1.3 The 4 national Research Governance Frameworks (RGF) for Health and Community Care (2006), updated to create an overarching UK Policy Framework for Health and Social Care Research (2017), promotes improvements in research quality and sets the standards for good practice.

1.4 At a local level NHS Fife, as part of Fife Partnerships is working towards greater integration of research and innovation activities in order to:

'Develop and make best use of knowledge from research, innovation and information resources to help achieve Fife's Population Health and Wellbeing Strategic priorities'.

1.5 For the purposes of this strategy 'Research' is defined as:

- All forms of clinical and population research involving patients or members of the public in Fife. This includes work that entails new data collection as well as the analysis of routinely collected data. It also includes research into care pathways that cross boundaries with other agencies.

'Development' is defined as:

- any systematic evaluation of the application of the results of research into practice.

'Innovation' is defined as;

- 'the act or process of introducing new ideas, devices, or methods'. Within healthcare, the World Health Organization (WHO) explains that 'health innovation' improves the efficiency, effectiveness, quality, sustainability, safety, and/or affordability of healthcare.

And 'Partners' are defined as:

- academic institutions, regional and national research networks and other agencies involved in, for example, Fife's Health and Social Care Partnership.

2. CURRENT RESEARCH, INNOVATION and KNOWLEDGE ACTIVITY

2.1 NHS Fife's annual research budget allocation of Support Funding from CSO (Chief Scientist's Office) was £830,000 in 2022-2023. These monies are provided for research considered eligible for funding, in recognition of the costs incurred by the NHS of undertaking and participating in such projects. This is currently the main source of funding available to support research in NHS Fife. Additional funding can be secured by increasing the number of eligibly funded projects[1] undertaken by an NHS organisation, increasing the number of NHS Fife Chief Investigators and the recruitment into such studies. Additionally, commercial research and a small number of specific grant funded projects undertaken across NHS Fife also provide funding to support key staff to be employed to enable the research to be undertaken. Commercial research does not attract support funding from CSO since all costs to the NHS of participating in such activities must be met in full by the participating companies. Income from commercial recruitment activity during 2022-23 was £107,000 (compared with £77,000 in 21-22, £135,603 in 20-21 and £99,850 in 19-20).

2.2 Funding is used to support research and development activities in NHS Fife. It provides the responsive and collaborative infrastructure (Appendix 1) necessary to ensure the required management and governance of the research undertaken. Appendix 2 illustrates the NHS Fife committee structure in relation to RIK.

2.3 There are 87 currently recruiting research projects registered across NHS Fife (compared with 103 in 21-22, 259 in 19-20 and 237 in 18-19). The top 6 Scottish Specialties in 2022-2023 in terms of recruited participants for Eligibly funded studies were: Reproductive Health & Childbirth (473), Trauma & Emergencies (393), Cardiovascular (131), Infectious Diseases & Microbiology (130), Stroke (59) and Respiratory Disorders (56).
There are currently 56 NHS Fife staff who are active as CI's and/or PI's, with 4 of these staff acting as PI for 4 or more clinical research studies.

2.4 Despite ongoing achievements it is recognised that there is still scope to increase the research and innovation capacity within NHS Fife. The recently completed Research Capacity and Culture Survey identified a lack of protected time, and a perceived lack of the relevance / importance and visibility of research as relevant. The Survey responses also identified that links with Universities, particularly the University of St Andrews were key to research and innovation growth.

[1] projects funded by any of the non-commercial charitable or government organisations detailed in the list of qualifying funders on the CSO website.

2.5 Every NHS organisation requires an appropriate balance of service delivery, research, innovation and learning in order to deliver the healthcare needs of the population. NHS Fife is predominately involved with service delivery supported by lifelong learning. Taking account of future demographic, social and technological change NHS Fife must increase the emphasis placed on research activity in order to support the delivery of the local health plan and Clinical Strategy into the future.

3. NHS FIFE'S VISION FOR RESEARCH, INNOVATION AND KNOWLEDGE

3.1 Strategy Aim

The RIK strategy will support NHS Fife's overall strategic aim to provide the highest quality care to, and improve the health of, the population of Fife, within the resources available and in partnership with its staff, community planning partner organisations and the citizens of Fife. The RIK strategy aligns with the NHS Fife Population Health and Wellbeing Strategy and will support the four priorities and ambitions within.
https://www.nhsfife.org/news-updates/campaigns-and-projects/population-health-and-wellbeing-strategy/

The RIK Strategy will support this by:

- promoting a culture that supports and encourages research and innovation as part of routine practice;
- building on the opportunities to work closely with academic and community planning partners to increase the volume and quality of research and innovation;
- promoting research and innovation within an appropriate governance framework;
- developing research and innovation knowledge and skills of staff and appropriate independent contractors;
- working in partnership with the citizens of Fife and Fife Community Advisory Council to ensure that all activity is patient-centered and is informed by patient and public input;

4. PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION

4.1 As a result of receiving R&D support funding from NRS and Innovation support through the Health Innovation Hub South East Scotland (HISES) considerable progress has been made in NHS Fife, supporting and encouraging research

and innovation activities. Work will continue to be taken forward within existing resources to make research and innovation meaningful and increasingly accessible and to ensure its integration into everyday practice and policy development.

4.2 We (NHS Fife) will continue to achieve this by:

- supporting the NHS Fife Executive Lead and Assistant Director Research, Innovation and Knowledge (RIK) to deliver against corporate and strategic objectives
- supporting the NHS Fife Research, Innovation and Knowledge Oversight Group
- advocating to include RIK information in recruitment and induction materials, personal development plans, knowledge and skills frameworks, contracts and terms of employment
- enabling access to the evidence base to support research and innovation by providing access to a full range of library services
- promoting research and innovation' achievements in Fife as part of clinical governance activities
- producing an annual report on research, innovation and knowledge activity for submission to Fife NHS Board and Clinical Governance Committee
- ensuring RIK is a high profile item for discussion on the agenda of appropriate NHS Fife meetings e.g. Clinical Governance Committee
- including measurable objectives for research and innovation within NHS Fife's RIK Strategy

5 WORKING WITH PARTNERS

5.1 NHS Fife currently works with a number of partners to take forward research and innovation. By improving the co-ordination and links at a senior level we aim to increase the volume and quality of research and innovation and the opportunities for Fife-based clinicians and other staff to become Principal / Chief Investigators.

5.2 In addition to supporting an NHS Fife Executive Lead/Assistant Director for Research Innovation and Knowledge we have achieved this by:

- enabling joint senior clinical appointments with our university partners
- identifying and supporting staff to nominate for honorary appointments with our university partners
- seeking opportunities to improve research and innovation collaboration with NHS Fife's Health and Social Care Partnership (HSCP)

- promoting multidisciplinary and multiagency research and innovation

- identifying local research and innovation education/training needs

- working with established regional and national networks (such as the Scottish Cancer Research Network (SCRN), Scottish Primary Care Research Network (SPCRN), Scottish Diabetes Research Network (SDRN), Scottish Stroke Research Network (SSRN), Scottish Mental Health Research Network (SMHRN), Scottish Neuroprogressive and Dementia Research Network (SDCRN), and Social Dimensions of Health Institute (SDHI), HISES, Scottish Health and Industry Partnership (SHIP) and InnoScot Health) to identify resources and mentors to provide support for staff undertaking research and Innovation.

- concentrating on developing and supporting developing researchers through targeted funding calls and support for applications for both research and Innovation Fellowships and following Fellowship completion.

<u>NRS Fellowships, Clinical Research and Innovation Champions and Clinical Innovation pre and post Fellowship support:</u>

  - Infectious Diseases
  - Orthopaedics
  - Palliative Care
  - Addiction Medicine
  - Women and Children's Health (Developmental Dysplasia of the Hip)

<u>Collaborative workshops:</u>

  - Digital Health Science Initiatives

  - Supporting the South East Regional Innovation Programme through our involvement with the South East Health Innovation Hub (HISES).

  - CSO Innovation Open Innovation Challenges and Consortium

Over the next 12 months we will:

- Continue to identify and prioritise joint clinical academic and honorary positions between NHS Fife and the University of St. Andrews
- Continue to improve the research and innovation culture within the clinical environment in Fife by supporting the nursing, allied health professional and supporting staff to establish their research and innovation priorities
- Support NHS Fife's vision in helping to shape /deliver the Clinical Strategy that meets the demands of future populations and COVID-19 recovery and resilience programmes

- Deliver the Joint Annual Collaborative Research and Innovation Symposium with the University of St Andrews

5.3 As a result of the above actions we will aim to:

- *increase the number of staff actively involved in Research and Innovation activity by 7.5% each year*

- *increase the number of ongoing projects, including eligibly funded /adopted projects as defined by the CSO, and commercial research within NHS Fife by 10% per year*

- *increase the number of publications by NHS Fife Staff in peer reviewed journals by 10% per year*

- *Increase the number of clinical academic positions by 10% over the next 3 years.*

6 PROMOTING RESEARCH AND INNOVATION WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK

6.1 Research and Innovation Governance is the framework through which NHS Fife Board can be assured that the quality of research and innovation is maintained and continuously improved and that high standards of patient care are maintained when research and innovation is carried out.

Research and Innovation Governance is used as an overarching term to describe the cohesive set of management and quality improvement systems to ensure NHS Fife meets its commitment to deliver high quality research and innovation, whilst protecting patients and researchers alike. The processes and procedures for Research Governance are much better developed and supported nationally and locally than Innovation Governance. The internal framework for Innovation Governance is being rolled out in 2022 and mirrors the process at HISES

The UK Policy Framework for Health and Social Care Research (2017) highlights 'the need for organisations to be aware of the activity involved in supporting research and of what it costs'. Further, as a minimum requirement, the CSO expects that as part of sound research governance arrangements NHS organisations should ensure that expert accounting input is available for the costing and monitoring of all research (both commercial and non-commercial). NHS Fife needs to be able to demonstrate to its auditors that it is covering the entire cost of undertaking research, including appropriate R&D Department costs and organisation overheads for commercial research. NHS Fife, therefore, needs to deliver rigorous and effective costing mechanisms and financial management in RIK.

This has been achieved in Fife through delivery of efficient research management and approval processes, developing research databases, providing support & training for researchers, ensuring financial probity, utilising

EDGE to monitor individual study costs and monitoring ongoing research and the publications arising from it.

Our approach to Research and Innovation Governance demonstrates to staff, users and carers that improving the quality of research and Innovation provided by NHS Fife is viewed as an important issue across the organisation.

6.2 In order to achieve this we will:

- ensure that all externally (out with NHS Fife) and internally (within NHS Fife) commissioned research undertaken in NHS Fife is registered and accurately costed
- Implement and refine the new Innovation Governance Framework
- ensure that policies are in place to support invention and innovation in NHS Fife while exploiting the potential these activities present for the organisation
- update, improve and develop NHS Fife policy, procedures and guidelines for commercial and non-commercial research and innovation
- ensure we undertake an annual monitoring exercise to identify all ongoing research and innovation
- ensure we undertake an annual audit of all research sponsored by NHS Fife
- ensure accurate data capture systems are in place to record RIK activity for analysis and dissemination
- maintain RIK tabs and links on the NHS Fife StaffLink Corporate hub and the RIK website
- hold regular awareness raising sessions around R&D, Innovation and Intellectual Property (IP)
- continue to employ a dedicated RIK Business Accountant from the NHS Fife Finance Directorate and have:
    - appropriate financial management, ensuring that the allocation of financial resources is effective & sustainable, bringing value to RIK as a service while providing guidance on the costs of research and recovery of such costs
    - costing mechanisms for commercial and non-commercial research
    - systems to identify patient recruitment to studies, raise invoices and track payments
    - systems that comply with financial probity to facilitate appropriate transfer of monies from one organisation to another
    - systems to accept, manage, monitor and disseminate funds.

- ensure that financial systems and audit trails are in place to capture and account for support funding expenditure and NHS Fife overheads from commercial research.

6.3 As a result of the above actions we will continue to:

- *provide R&D support for every research project registered in NHS Fife*
- *provide assurance to NHS Fife Board that all research activity meets the requirements of the UK Policy Framework for Health and Social Care Research*
- *increase the identification and protection of intellectual property by 5% each year thereby increasing commercialisation activity, increasing both financial and healthcare benefits for NHS Fife through opportunities arising from the HISES Innovation Programmes*
- *ensure that a minimum of 10% of all 'high risk' projects[2] sponsored by NHS Fife are audited annually.*
- *continue to provide accurate regular updates and annual reports on financial expenditure and research activity to the CSO*
- *continue to provide financial information for the NHS Fife Research Innovation and Knowledge Annual Report*
- *continue to identify the actual cost of research undertaken in NHS Fife and maximise our returns from commercial research.*
- *Maximise utilisation of the Clinical Research Facilities and explore opportunities for extension.*

7 WORKING IN PARTNERSHIP WITH STAFF

7.1 Research and Innovation is undertaken by and with staff for the benefit of patients and members of the public. It is essential that we work with staff and the Public Partnership Forum to promote the benefits of research and innovation activity for individual staff members as part of their commitment to personal development.

Research and Innovation activity depends on staff having appropriate skills. The Assistant RIK Director and RIK Team will, in collaboration with other NHS organisations, university partners and external agencies and within existing resources, provide the necessary information for staff to access regular research education and workshops both within and out with NHS Fife.

7.2 In order to achieve this we will continue to:

[2] projects where the potential for an adverse event is deemed to be higher, such as those involving investigational medicinal products, devices or investigations. NB NHS Fife does not currently sponsor Clinical Trials of Investigational Medicinal Products.

- Identify / determine research and innovation education needs within NHS Fife

- encourage staff to consider research and innovation training and education and the development of evidence-based practice as part of their CPD

- work jointly with other external organisations to promote access to high quality multidisciplinary/multiagency programmes which address identified research and innovation training requirements

- encourage and support NHS Fife staff to apply for NRS Research Fellowships, CSO Clinical Innovation Fellowships, Doctoral Training Programme Fellowships and other programmes, details of which will be circulated throughout NHS Fife.

- identify sources of funding and work towards securing funds in partnership with new and established researchers and innovators to undertake research and innovation within the identified priorities and needs areas.

7.3 As a result of the above actions we will, in addition to increasing the percentage of staff actively involved in research and innovation activity:

  - *review the demand and access to research and innovation training and education, plan and determine access to widely accessible programmes out with NHS Fife and with university partners aimed at increasing the capability of staff to undertake research and innovation*

  - *increase the number of staff participating in research and innovation training and education both within and out with NHS Fife*

  - *support staff aspirations in registering for higher degrees.*

8 PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH AND INNOVATION

8.1 It is important that the organisation has systems in place to identify the involvement of consumers in research and to ensure their involvement in the development and execution of research projects.

8.2 In order to achieve this we will continue to:

- ensure that there is patient and public representation on relevant RIK groups
- encourage the involvement of patients and the public in the development of studies and patient information relating to research and innovation projects

9 COMMUNICATING RESEARCH AND INNOVATION INFORMATION ACROSS NHS FIFE

9.1 Two-way communication of Research and Innovation information across NHS Fife presents a significant challenge due to the dispersed nature of the

organisation. In light of this, established communication networks are used where possible.

9.2 Health & Social Care Partnerships, the Division and Corporate Directorates use current systems such as StaffLink, local newsletters, briefing sheets or web sites to disseminate information about local and National research initiatives.

9.3 RIK has presence on StaffLink along with a RIK website. Relevant information and updates will also continue to be provided via the monthly electronic bulletin, quarterly newsletter and on the website and the RIK Twitter account. Updates to this information will be supported by staff within RIK and co-ordinated by the Assistant RIK Director.

9.4 The NHS Fife Research, Innovation and Knowledge Oversight Group will continue to be actively involved in promoting research awareness, the RIK Strategy and communicating the benefits of Research and Innovation to staff, users, carers and other partner organisations in Fife, Scotland and the rest of the UK.

10 PLAN OF ACTIVITIES AND PRIORITIES FOR 2023-24

11.1 In order to ensure the continued implementation of this wide-ranging strategy, it has been agreed that a number of strategic 'priorities' will be selected annually, to be advanced throughout the year, and reported on at the year end. These priorities are included in Appendix 3.

12 REVIEW

This Strategy and Plan of Activities and Priorities will be reviewed in August 2024 leading to refinements to the first Research, Innovation and Knowledge Strategy and Annual Priorities from November 2024.

References

1. UK vision for clinical research delivery (launched March 2021)
2. The Future of UK Clinical Research Delivery: 2022 to 2025 implementation plan
3. Delivering Innovation through Research (2015)
4. Scottish Office Department of Health Research Strategy (2009)
5. UK Policy Framework for Health and Social Care Research (2017)
6. Scottish Office Department of Health Funding Manual (2004)
7. Policy Framework for the Management of Intellectual Property within the NHS Arising from Research & Development MEL (1998)23.
8. Management of Intellectual Property in the NHS. HDL (2004) 09
9. NHS Fife Population health and wellbeing strategy (2023–2028)

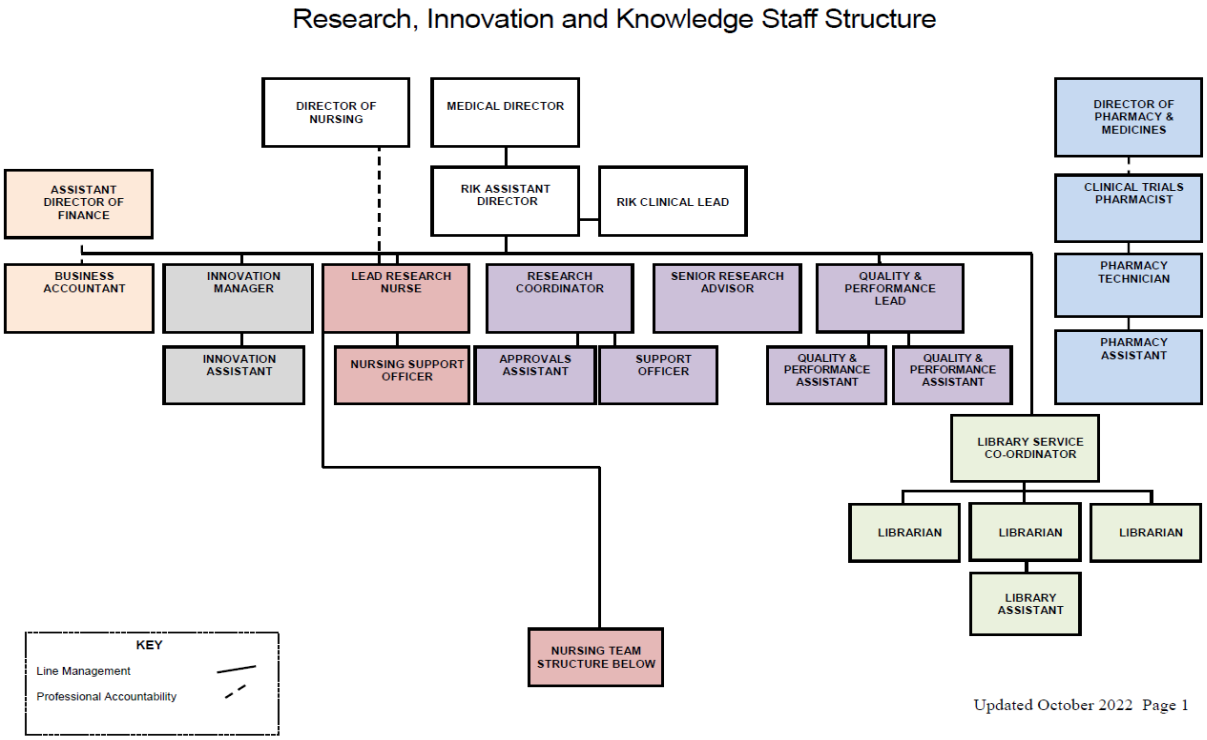
13 RECOMMENDATION

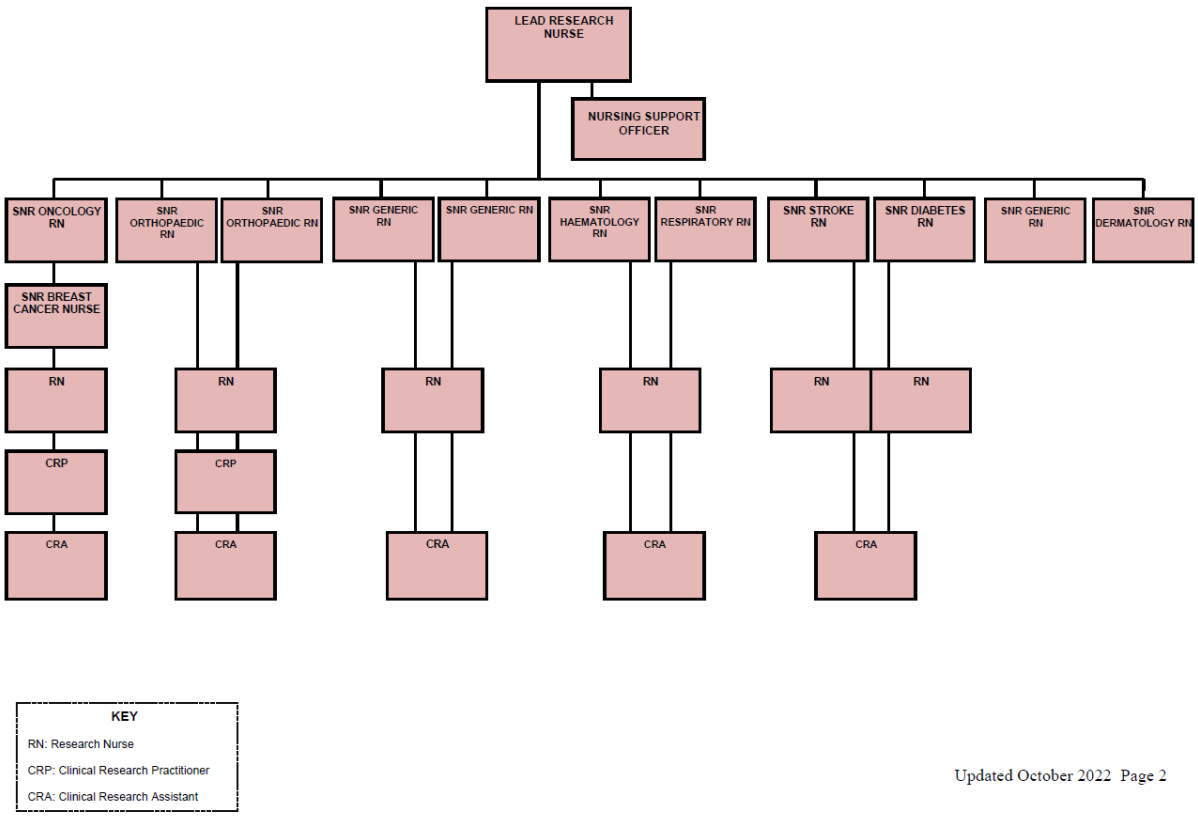
This paper is provided for:

- Assurance

Appendix 1

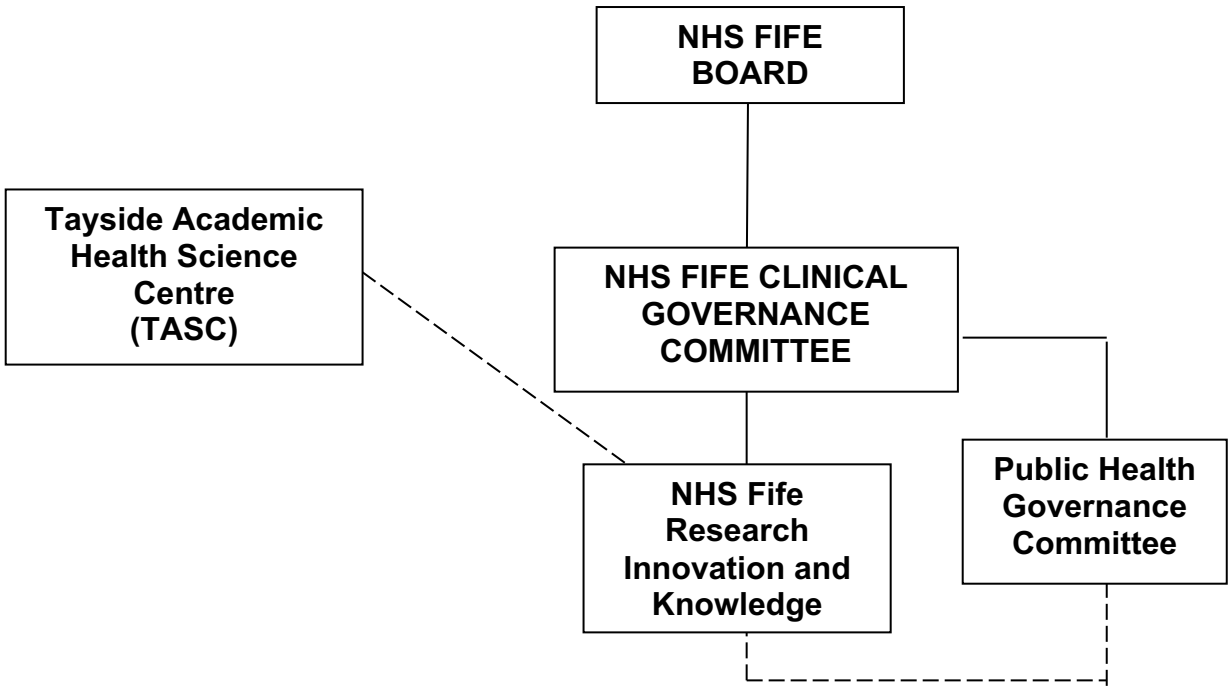
NHS Fife Research, Innovation and Knowledge Support Structure 2022-23





Appendix 2

COMMITTEE STRUCTURE / NHS FIFE IN RELATION TO RESEARCH, INNOVATION AND KNOWLEDGE



Accountability ————

Communication _ _ _ _ _ _ _ _ _

Appendix 3

PLAN OF ACTIVITIES AND PRIORITIES FOR 2023-24

The following plan of activities has been developed from the current NHS Fife RIK Strategy. To ensure delivery, activities have been prioritised and resource requirements determined. Completion of this plan will better position NHS Fife to: seriously address the research and innovation agenda; compete in the national research and innovation arena; attract new and retain existing staff; whilst improving healthcare for the citizens of Fife.

(A) PROMOTING A CULTURE THAT SUPPORTS AND ENCOURAGES RESEARCH AND INNOVATION.

Investment in new clinical posts (medical, psychology, allied health professional, nursing and supporting staff) in order to establish meaningful clinical academic positions and/or active researchers or innovators with identified and protected time.

A1. To continue to encourage discussion of research and innovation as part of normal Personal Development Plans and appraisals of health care staff.

A2. To continue RIK participation in the development of the medical, nursing and allied health professional clinical academic career development in Fife.

A3. To continue to support and participate in NHS Research Scotland (NRS) East of Scotland research node with St Andrews and Dundee Universities, and NHS Tayside by establishing for example joint standard operating procedures, co-sponsorship agreements.

(B) WORKING WITH PARTNERS.

Establish a mutually meaningful and productive link with academic institutions

In order to establish this NHS Fife will continue to:

B1. Identify and understand corporate arrangements with institutions such as St Andrews, Dundee, Edinburgh, Napier, Queen Margaret and Abertay Universities to facilitate collaboration.

B2. Continue investment (financial or other) with academic institutions (especially St Andrews University Medical School) that will result in a critical mass of research and innovation active individuals, employed/seconded by NHS Fife and/or universities to build research and innovation capacity and governance structures.

(C) PROMOTING RESEARCH WITHIN AN APPROPRIATE GOVERNANCE FRAMEWORK AND SECURING APPROPRIATE SUPPORT TO ENSURE FINANCIAL PROBITY

In consolidating the research and innovation governance structure the current areas that need to be considered include:

C1. Continuing to identify commonalities / engagement between the clinical, research, innovation, quality improvement, digital and e/health, information governance structures within NHS Fife.

C2. Consolidate preparations for future inspection(s) from Medicines and Healthcare products Regulatory Agency.

Increasing the income generated from increased research activity, creating opportunities to further enhance and invest in research programmes in Fife by:

C3. Maximising commercial research opportunities locally and in collaboration with external partners.

(D) WORKING IN PARTNERSHIP WITH STAFF AND COMMUNICATING RESEARCH INFORMATION ACROSS NHS FIFE.

Consolidate a research and innovation communication strategy with all NHS Fife communities.

Communication is the linchpin of creating a research and innovation focused culture. During 2023-24 we will:

D1. Deliver regular NHS Fife RIK news updates, bulletins and newsletters.

D2. Produce and disseminate an NHS Fife RIK Annual Report.

D3. Support research and innovation workshops for patients, carers and other citizens of Fife

(E) PATIENT AND PUBLIC INVOLVEMENT

E1. Develop ongoing, meaningful engagement of the public in research

Prof Frances Quirk
Assistant RIK Director
NHS Fife

December 2023
These priorities have been discussed and agreed by the NHS Fife RIK Operational Group and the NHS Fife Research, Innovation and Knowledge Oversight Group.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Research, Innovation and Knowledge Annual Report 2022-2023**
Responsible Executive:	**Dr Chris McKenna, Medical Director and Executive Lead Research, Innovation and Knowledge**
Report Author:	**Professor Frances Quirk, Assistant Director Research, Innovation and Knowledge**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Research, Innovation and Knowledge Annual Report 2022-2023 is being brought to the Clinical Governance Committee for their Awareness to provide an update on activities in increasing culture to include research and innovation as part of roles and to build research and innovation capacity and delivery against 2022/2023 strategic priorities.

2.2 Background

This report details the activities within Research, Innovation and Knowledge across NHS Fife from April 2022 to March 2023. It details progress made over the last 12 months in relation to ongoing work, previously identified challenges and identifies the key challenges currently facing Research, Innovation and Knowledge (RIK).

Continued significant developments within RIK include our relationship with the Universities of St Andrews, Edinburgh and Dundee in relation to research and innovation

activities and education and training. The joint clinical academic appointments with the University of St Andrews have produced benefits in terms of collaboration, Doctoral Training Fellows and contribution to an expanding NHS Fife research culture. The successful Inaugural NHS Fife and University of St Andrews Research Symposium in October 2022 contributed significantly to a greater sense of partnership.

The format of the report has been revised to reflect feedback from the lay representative member of the Research, Innovation and Knowledge Oversight Group and input from the Fife Community Advisory Council.

2.3 Assessment

During 2022-23 the research and innovation culture within NHS Fife has maintained recent advances, delivering: consistent levels of research activity, growing innovation activity, increased numbers of clinical academics; compliance with the research governance framework, development of an innovation governance framework, monitoring 100% of Fife Sponsored studies; and the delivery of a RIK Education Programme albeit revised to accommodate ongoing Covid restrictions.

The following challenges have been amalgamated from unmet objectives from the 2022-23 RIK Strategy Key Performance Indicators (KPIs), and the NRS objectives & associated performance metrics to be delivered during 2022-23:

Unmet KPIs (R&D Strategy2022-23):

- Increase the number of staff actively involved in research
- Increase non-commercial income

.

R&D Strategy priorities (2022-23):

All activities detailed in the prioritised plan of the RIK Strategy for 2022-23 are ongoing or have been achieved.

2.3.1 Quality, Patient and Value-Based Health & Care

-

2.3.2 Workforce

The restarting of non-COVID studies and the commitment to commence new studies, along with the impact of changes to work patterns, have led to some resourcing implications and challenges for staff in RIK. The wellbeing of staff is considered a priority and this has been an ongoing focus with the appointment of a Wellbeing Champion.

2.3.3 Financial

Research is categorised as 'commercial' (funded by the pharmaceutical or medical device industry) or 'non-commercial'. Non-commercial research is further divided into "eligible" (funded by charitable organisations, research councils or Government bodies), or "non-eligible" (NEF - funded by a non-eligible organisation or is unfunded).

R&D funding is provided via NHS Research Scotland (NRS) by the Chief Scientist Office (CSO) in respect of research considered 'eligible' for funding, in recognition of the unfunded costs incurred by the NHS for undertaking and participating in such projects.

CSO funding remains the main source of income to support all non-commercial R&D activities across NHS Fife. It is used to provide and support the R&D infrastructure (Appendix 2), to maximise its activity and to ensure the required management, governance and support of research.

CSO Funding Allocation Income 2022-2023 -£830,000 (with an additional £15,000 uplift to accommodate the 7.5% pay award to a total of £845,000)

Commercial Income 2022-2023- £107,000

Cost Savings (Pharmacy and Medicines) 2022-2023 -£198,000

2.3.4 Risk Assessment / Management

Research, Innovation and Knowledge Oversight Group has noted changes in the number of staff involved in research, commercial income, non-commercial income and cost savings generated over the reporting period. These KPI's will be a focus of monitoring and the development and implementation of strategies to address them in 2023-2024.

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

-

2.3.6 Climate Emergency & Sustainability Impact

-

2.3.7 Communication, involvement, engagement and consultation

Two-way communication of Research and Innovation information across NHS Fife has improved despite the challenges of the dispersed nature of the organisation. The creation of Clinical Research and Innovation Champion roles (first appointed cohort 2022-2024: Dr Devesh Dhasmana, Dr Susanna Galea-Singer, Mr Phil Walmsley) will support professional engagement within NHS Fife and across our stakeholders (the University of St Andrews and the South East Health Innovation Hub). To further facilitate communication, key research information is available via a dedicated NHS Fife RIK webpage, weekly updates, and monthly or quarterly bulletins and newsletters. The format of these has been revised to take advantage of newly available platforms, such as SWAY.

Internal Communications

Updates on the research training programme, R&D support and details of research and innovation conferences are circulated regularly. A monthly Publications Bulletin circulated via email and shared with stakeholders provides visibility of the range of publications

including NHS Fife authors. Monthly electronic research 'bulletins' are sent to all research/innovation active staff (past and present), providing up to date information about advice clinics, seminars, workshops and recently issued commissioned bids / grants - within and out with NHS Fife.

Details of events and training opportunities have been regularly included in the electronic organisation-wide 'StaffLink'. To reach staff that do not have access to email, details of the RIK Department, its staff and the support offered have been placed on electronic notice boards and sites across the organisation.

External Communications

Work is ongoing on a fully refreshed RIK website www.nhsfife.org/research with dedicated Clinical Research Facility, Publications and News Updates pages. The website has been updated to reflect the transition from R&D to Research, Innovation and Knowledge (RIK).

Generic R&D email address have been created to maximise the efficiency of responses to queries to the department, fife.randd@nhs.scot and for R&D news fife.rdnews2@nhs.scot

Our Public Involvement representative with a special interest in research is a member of the joint University of St Andrews and Fife Community Advisory Committee (FCAC). They have been an active member of the NHS Fife Research, Innovation and Knowledge Oversight Group in their role as Lay Advisor.

The FCAC assist in providing lay view/input into the development of research proposals and ongoing research, and help raise awareness and understanding of research being undertaken locally. The FCAC are invited to review and feedback on our Annual Report and RIK Strategy prior to their finalization.

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.

- Research, Innovation and Knowledge Operational Group- reviewed and feedback requested and responded to (1st November 2023, by circulation)
- Fife Community Advisory Council- reviewed and feedback requested (December 2023)
- Research, Innovation and Knowledge Oversight Group- reviewed and feedback requested (11th December 2023)

This paper will also be submitted to the Executive Directors Group in the first meeting of 2024

- Executive Directors Group – for Awareness (18th January 2024)

2.4 Recommendation

This paper is provided to members for:

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

3 List of appendices

The following appendices are included with this report:

Appendix No 1 - Research, Innovation and Knowledge Annual Report 2022-2023: available at this link: RIKAnnualReport_22-23.pdf

Report Contact
Professor Frances Quirk
Assistant Director Research, Innovation and Knowledge
Email frances.quirk@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Committee Self-Assessment Report 2023-24**
Responsible Executives:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

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

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in late January 2024. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee and have been invited to consider what improvement actions might be necessary to be taken forward in the year ahead. A summary report assessing the composite responses for the Clinical Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference and no significant matters of concern were raised. It was noted that attendance of members is generally satisfactory and that pre-Committee meetings with the Non-Executive membership give an opportunity to discuss the appropriateness of the meeting agenda, queries to be addressed and its focus on matters of significance. The Chair has made further comments on the content of the draft Clinical Governance Committee induction pack, which is currently being created, and these are being taken forward separately, prior the pack's finalisation and its roll-out for new members.

Self-Assessment questionnaire (completed by members and attendees)

In total, all ten members (excluding the Chair) and six (of eight) regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a relatively positive assessment from its members and attendees who participated, though there were some areas identified as in need of further work. The addition of Committee-level Development Sessions to allow for greater briefing / training opportunities has been welcomed, and it is suggested that regular communication with members between meetings could allow for more information to be made available by circulation on emerging issues or national strategies and initiatives (which would also assist in the management of the size of meeting agenda packs). The need for the Committee to maintain a focus on strategic, rather than operational, detail was a common theme, which is an important factor in ensuring the correct governance focus of the Committee versus its sub-structure of reporting groups. There would be potential for this to be teased out further with members' input.

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

- further work required on making agendas and meeting packs manageable in the time allowed for meetings, particularly limiting the frequency of data-heavy appendices and making more use of executive summaries with the SBAR itself (it had been anticipated that the set-up of the Public Health & Wellbeing Committee should have helped spread more of the load of required business, but it is clear this still needs refinement);
- related to the above, the distribution of late papers for meetings should be minimised where at all possible, given the pressures on members of reading an already lengthy agenda pack (this might require the Chair to reject any committee papers submitted passed the deadline);
- a number of comments indicating that a Development Session on key Clinical Governance principles and members' roles and responsibilities (including discussion on whether the current membership / front-facing clinical representation is sufficient) is likely to be beneficial, given that the Committee's subject area is complex for those from a non-clinical background;
- review of the role and participation of routine attendees, with the need to be clearer about each attendee's purpose in attending the meeting; and
- the opportunity to add a short closing section to the agenda, for the Chair's closing remarks, to reflect and seek feedback on how the meeting has progressed.

Some of the issues noted above are not unique to the Clinical Governance Committee and indeed are common across a number of Board committees, particularly those with wide-ranging remits. Board-wide enhancements to agendas (to add timings for items and to list explicitly thereon whether the agenda item is for assurance, approval etc.) are presently being planned for introduction from the May cycle of meetings. Suggestions from members of greater separation between Non-Executive and Executive members, to increase clarity around who is holding whom to account, require further discussion at Board-level, given the implications for other committees, and this will be taken forward in discussion with the new Board Chair.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered initially by the Committee Chair, Lead Executive Director and Board Committee Support Officer.

2.3.8 Route to the Meeting

The Committee is the first group to receive this paper.

2.4 Recommendation

This paper is provided for:

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

3 List of appendices

The following appendices are included with this report:

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

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

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics						
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	3 (19%)	12 (75%)	1 (6%)	-	Yes, it is, but I am unclear about its authority and role as it is straying into operational matters on a regular basis. I think there should be more attendance from front-facing clinical staff. Committee has full membership and acts with authority. It is also well supported by the corporate admin team.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	5 (31.5%)	11 (68.5%)	-	-	Not all members or attendees contribute to meetings. It would be helpful to hear occasionally more from managers involved in the day to day.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	1 (6%)	13 (81%)	2 (12.5%)	-	Operational in nature, with matters taking too long. The past year has seen a positive improvement in participation and acceptance of responsibilities and roles. Committee membership has changed significantly in the last 18 months. There is very active participation during meetings and scrutiny of papers. Non-Executive and Executive membership require clearer delineation in this committee - the Executive leads for areas are to be held to account by Committee.
A4.	Committee members are able to express their opinions openly and constructively.	4 (25%)	10 (62.5%)	2 (12.5%)	-	Lack of contributions from the entire Committee, same presenters continually. Opinions not sought. The scale and size of agendas and papers make it challenging for members to have time and be able to express opinion on the wider range of items.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						The meetings are generally held in a very open and collegiate manner. Opinions offered are mostly discussed in a professional and improvement focussed manner. There have been occasions when the Executive have suggested we take assurance from the very existence of a clear governance structure and tried to give assurance themselves on the effectiveness of these. In doing so have stopped questioning. We need to be able to evidence the output from these groups as being effective at supporting clinical quality and strategic objectives.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	3 (19%)	12 (75%)	1 (6%)	-	This tends to become operational. As stated at A3, the past year has seen a positive improvement in participation and acceptance of responsibilities and roles. The Chair encourages constructive challenge. Committee members are interested and curious about the issues brought to them. There is a balance sometimes towards greater operational interest in topics than can be fulfilled within this setting- discussions are taken off-table if necessary. Think this needs a bit more 'show me, don't tell me'.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	-	15 (94%)	1 (6%)	-	There have been development sessions and walkabouts. Sometimes training needs / gaps in knowledge are identified after the fact, but stakeholders have been open to further discussion with Committee members to further understanding. The development days are a very useful tool. However, on occasion, in respect of matters 'Emerging Issues' and statutory notices/inspections, there could possibly be a lag or gap in these inputs.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	-	16 (100%)	-	-	Again, through development sessions this has improved. The Committee engenders a good level of discussion which helps promote better understanding of areas where a member may be lacking in knowledge - stakeholders are very open to questions prior to meetings to help increase understanding as well. We could perhaps benefit from greater medically qualified members.
B. Committee meetings, support and information						
B1.	The Committee receives timely information on performance concerns as appropriate.	1 (6%)	14 (87.5%)	1 (6%)	-	A complex area though to establish if full understanding and impact is known from the information provided. Partially agree. On occasion there appears to be too much of a lag in reporting, meaning that performance may have improved/deteriorated, since the report presented/ being discussed. There are some unavoidable lag-times between the end of a quarter and publication of data, but this is balanced with robust narrative update from topic leads.
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	1 (6%)	14 (87.5%)	1 (6%)	-	There could possibly be an 'off table' brief provided on inspections and matters from external regulators, particularly where failings or omissions are identified. This would ensure that when the matter is reported to Committee it would be more of an update than a notification, this would in turn assist to retain the focus of the topic presented and inform the appropriate scrutiny and/or support to Executives and their teams. Good examples are on maternity and neonatal and where we have received reports on external scrutiny.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	-	14 (87.5%)	1 (6%)	1 (6%)	Excessive volume of papers. As above, there could possibly be an 'off table' brief provided on relevant strategies, policies directions and instructions. This would ensure that when the matter is reported to committee it would be more of an update than a notification, this would in turn assist to

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						retain the focus of the topic presented and inform the appropriate scrutiny and/or support to Executives and their teams.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	-	13 (81%)	2 (12.5%)	1 (6%)	Occasionally, there is an 'excessive number' of pages to cover, mindful of need to prepare, scrutinise, digest. Excessive information. Too excessive. I think the number of papers and the length of the papers can sometimes feel overwhelming. Generally, the information and data provided is appropriate. This is a perpetual challenge as the Committee has a wide remit. It did seem as though the Public Health Committee would go some way to addressing the lengthy agenda, however the papers have become somewhat voluminous once again. I would prefer to see more focused, in-depth discussion (and shorter papers) on the main issues of concern as opposed to in-depth detail on every agenda item. This should perhaps be reserved for the work of the supporting groups and committees /sub committees that sit beneath the CGC? Otherwise, there is a danger that important information gets lost amongst a deluge of other information. Generally, the cover papers for Committee using the standard SBAR template are very helpful, and authors understand the importance of limiting the size of the packs. However, this Committee can have very large meeting-packs and the difficulty is usually from large attachments. This can impact on the ability of all members to read material in advance of meetings.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	4 (25%)	10 (62.5%)	2 (12.5%)	-	Due to excessive volume.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						For the most part, although time constraints can mean some papers are only available close to the meeting. This can make it difficult to ask stakeholders questions prior to the meeting to increase understanding. Mostly agree. Whilst appreciating the time required of individuals to prepare papers, depending on the topic and the data supporting, seven days can sometimes be too little, particularly if there is more than one Governance committee in the same week. Late papers can add to the time pressures. I only disagree because usually the Board committees and IJB committees are usually scheduled for the same week. It would be great if the committees could be spread out a bit more although I appreciate it has to fit with the board cycle and work has been undertaken already to address this. There is a robust approach to setting agendas and circulating papers in advance of meetings.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	-	12 (75%)	2 (12.5%)	2 (12.5%)	Meetings overrun with agendas that are too full. Some items take too long. Occasionally. important papers feel a bit rushed if at end of agenda. The meeting is too long, and, at times, there is too much focus on one area leaving little time for other agenda items. There is also information submitted which is not clinical governance related. Mostly agree. Occasionally the timings allowed for papers are not sufficient, which then means the time pressure to complete the meetings within the allocated time can stifle the ability to properly scrutinise/discuss later agenda papers. It is particularly noticeable for information/data heavy papers. This is inherently unfair on individuals who are attending to speak to the paper in question. Again, this requires a tight focus. The Chair does a good job of keeping on track, but the agenda is often so heavy that important matters need to be rushed through. Agendas are often very long - potential to review this?

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						Agenda could benefit from further review and refinement of linked minutes. There appears to be a disproportionately 'heavier' agenda compared to other committees. There are occasions when time has run out to discuss items and sometimes these are carried over to the next meeting.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	9 (56%)	7 (44%)	-	-	Minutes are of a very high quality.
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	10 (62.5%)	6 (37.5%)	-	-	-
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's strategies, policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	5 (31%)	11 (69%)	-	-	The Chair is very much on top of risk management and the provision of a good level of assurance. I question the point on strategy for all committees. It is difficult to see the actual impact on longer term strategy, especially where Performance is not improving.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub groups) is operating effectively as part of the overall governance framework.	1 (6%)	15 (94%)	-	-	Sometimes there is uncertainty about the delegation and which Committee is leading.
C. The Role and Work of the Committee						

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C1.	The Committee reports regularly to the Board verbally and through minutes, can escalate matters of significance directly and makes clear recommendations on areas under its remit when necessary.	6 (37.5%)	10 (62.5%)	-	-	The Chair always checks at the end of meetings on any matters for escalation.
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	-	14 (87.5%)	2 (12.5%)	-	This varies and is very operational at times. No Executives direct the Executive team rather than scrutinise. The past year has seen an improvement in the understanding of all Committee members of the correct focus and reasons for this. There is always a danger the Committee can lose sight of its strategic focus. However, on occasion, there is a tendency to move toward operational detail. Agenda too long, too many papers; as such, not high enough level.
C3.	The Committee's agenda is well managed and ensures that all topics with the Committee's overall Terms of Reference are appropriately covered	2 (12.5%)	11 (69%)	2 (12.5%)	1 (6%)	Agenda is a major issue - too long, too many items. The meeting is very long with lots of information to review, which can make keeping focussed a challenge. Mostly agree. Occasionally the timings allowed for papers are not sufficient, which then means the time pressure to complete the meetings within the allocated time can stifle the ability to properly scrutinise/discuss later agenda papers. It is particularly noticeable for information/data heavy papers. This is inherently unfair on individuals who are attending to speak to the paper in question. Agree, but please see previous comments re lengthy agenda and papers. Notwithstanding earlier comment re linked minutes.
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	2 (12.5%)	14 (87.5%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	Review the agendas, scrutinise data, avoid operational challenge, stay focused. Seek views. Balancing need for detail against level of scrutiny. Less volume of information, more focus on particular topics at meetings. Ongoing development of Non-Executive members with the Chair and responsible Executive Director to ensure that we are all confident of our roles, and that our level of scrutiny is appropriate - is there a way to validate this, perhaps using an external perspective or peer review? As stated earlier, off table briefings on urgent and or emerging matters, particularly if matters are performance or legislature relevant, time critical or if it occurs early in the next meeting cycle timeline. Outside of the workplan, a relentless focus on emerging themes and issues round patient safety and risk that the Board must be sighted on. Greater representation of staff who work in patient safety and quality-related roles. We need to be thinking about linking performance to quality of care - where we are not meeting targets, we need to understand why but also consider the actual impact and set expectations and objectives accordingly. Perhaps limiting size of papers which can be received and asking for 'Executive Summary' for all reports?				
D. Clinical Governance Committee specific questions						
D1.	The Committee is provided with appropriate assurance that the corporate risks related to the specific governance areas under its remit are being managed to a tolerable level.	1 (6.25%)	14 (87.5%)	1 (6.25%)	-	The effectiveness of Deep Dives needs to be reviewed. Further work on the evidence and factors influencing risk needs to be developed. I agree that for some risks, operating outside of appetite, there is assurance given that all aspects within the gift of the Board to manage are being undertaken. On other occasions, there is limited if any assurance that progress is being enacted in a timely manner, or reasons why this may be the case.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
						Significant work has been undertaken in this area over the last 2 years. We need to question the impact of mitigation.
D2	There is appropriate coverage of the key components of the Committee's remit in meeting agendas (i.e., as an example, for Clinical Governance, the full range of clinical governance activity, including Patient Safety, Quality of Care, Clinical Effectiveness and Patient Experience, is reviewed during the year - and similarly so for other committees).	3 (19%)	10 (62%)	3 (19%)	-	This varies. Some items are laboured, and others of importance are skimmed. The volume of information can make coverage at more than a superficial level challenging. Time limitations. The Committee annual workplan and agenda generally ensure this is the case. The Committee has a very full agenda and workplan which can make this challenging to complete within the year.
D3.	The performance information and data presented to the Committee allows for easy identification of deviations from acceptable performance (both negative and positive).	-	14 (87.5%)	1 (6%)	1 (6%)	Due to the volume and technical nature of some of the information I think that deviations could be missed. There is always room for improving how information and data is presented so it's about reviewing on a regular basis. Generally, this works well, although there are some unavoidable lags in publication of information / data.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
D4.	Where there is a negative deviation from acceptable performance, the Committee receives adequate information to provide assurance that appropriate action is being taken to address the issues.	-	13 (81%)	3 (19%)	-	Think this is variable depending on performance area. I agree that for some risks, operating outside of appetite, there is assurance given that all aspects within the gift of the Board to manage are being undertaken. On other occasions there is limited if any assurance that progress is being enacted in a timely manner, or reasons why this may be the case. This is difficult to see in some cases. Within the constraints of other factors and risk appetite.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Annual Review of Committee's Terms of Reference**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This report is presented for:

- Decision

This report relates to:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2023, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. Proposed amendments are either general updates to enhance clarity of text, or are included to address outstanding internal audit recommendations (such as the addition of a clause, in Section 5, around the management of risks related to Information Governance & Security).

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each

standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

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

2.4 Recommendation

This paper is provided for

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

3 List of appendices

The following appendices are included with this report:

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

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

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

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

~~1.3~~ To oversee the clinical governance and risk management actions and activities in relation to the delivery of the ~~existing Clinical~~ Board's Population Health & Wellbeing Strategy~~.~~

~~1.4~~1.3 ~~To evaluate agreed actions relevant to clinical governance in the implementation of the developing Population Health & Wellbeing Strategy,~~ including assessing the quality and safety aspects of new and innovative ways of working.

~~1.5~~1.4 To assure the Board that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities. This includes planning, maintaining and improving quality.

~~1.6~~1.5 To oversee patient experience and feedback mechanisms and associated activity and seek assurance that learning and ongoing improvements are responsive to complaints feedback and in line with national standards and Ombudsman guidance.

~~1.7~~1.6 To assure the Board that the clinical and care governance arrangements in the Integration Joint Board are working effectively.

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

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

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

- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum

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

- Director of Acute Services
- Director of Finance & Strategy
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Associate Director, Digital & Information
- Deputy Medical Director, Acute Services Division
- Deputy Medical Director, Fife Health & Social Care Partnership
- Associate Director of Quality & Clinical Governance
- Associate Director of Risk & Professional Standards
- Board Secretary

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

3. QUORUM

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

4. MEETINGS

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

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

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

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

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

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

- ensure appropriate alignment and clinical governance oversight with the ~~emerging Programmes reporting through EDG~~individual workstreams of the Strategy (i.e. Integrated Planned Care Programme; Integrated Unscheduled Care Programme; High-Risk Pain Medicine Programme);

- provide assurance to the Board that there are effective systems and processes in place to support the management and mitigation of risks related to Information Security & Governance;

- receive the minutes and assurance reports from the meetings of:
  - Area Clinical Forum
  - Area Drug & Therapeutics Committee
  - Area Radiation Protection Committee
  - Cancer Strategy & Governance Group
  - Clinical Governance Oversight Group
  - Digital & Information Board
  - Health & Safety Sub Committee
  - Infection Control Committee
  - Information Governance & Security Steering Group
  - Integration Joint Board Quality & Communities Committee
  - Research, Information & Knowledge Oversight Group
  - Resilience Forum

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

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

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

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

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

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

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

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

6. AUTHORITY

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

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

7. REPORTING ARRANGEMENTS

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

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

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Corporate Risks Aligned to the Clinical Governance Committee, including Deep Dive: Optimal Clinical Outcomes**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the risks aligned to this Committee since the last report on 12 January 2024, along with the scheduled Deep Dive review.

The Committee is invited to:

- note the corporate risks as at 15/02/24 set out at Appendix No. 1;
- consider Deep Dive Review: Optimal Clinical Outcomes, set out at Appendix No. 2;
- review all information provided against the Assurance Principles at Appendix No. 3; and the Risk Matrix at Appendix No. 4;
- conclude and comment on the assurance derived from the report

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 31/01/24 is provided at Table 1 below.

Table 1: Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◄►	High
To improve the quality of health and care services	6	5	1	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	**18**	**13**	**5**	**0**	**0**		

Summary Statement on Risk Profile

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

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

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

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

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

Table 2: Risks Aligned to the Clinical Governance Committee

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1		-	-	◀▶	• 5 - Optimal Clinical Outcomes	• Mitigations updated
To improve the quality of health and care services	-	1	-	-	▲	• 9 - Quality and Safety	• Current and target risk scores reduced • Mitigations updated
To deliver value and sustainability	2	1	-	-	◀▶	• 16- Off Site Area Sterilisation and Disinfection Unit Service • 17- Cyber Resilience • 18 - Digital and Information	• Mitigations updated for Risks 17 and 18

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

- One risk has been closed - Covid-19 Pandemic
- Five risks are now aligned to the Committee
- One risk has reduced its risk rating and level - Quality & Safety
- The risk level breakdown is - 3 High and 2 Moderate
- No new risks have been identified

Details of all risks are contained within Appendix No. 1.

Risk Updates

Risk 3 - COVID - 19 Pandemic

At the last meeting of the Committee, the Director of Public Health provided a report and a Deep Dive Review which showed that the Covid-19 risk had achieved its risk target and that there had been a period of stability in reviews of the risk over several months. It was recommended that the risk should close on the Corporate Risk Register and oversight should transfer to the Public Health Assurance Committee. The Committee took assurance on the Deep Dive and agreed on the recommendation. This has been actioned.

Risk 4 - Optimal Clinical Outcomes

Following discussion at the Clinical Governance Committee on 5 May 2023 and the Committee's Development Session on 23 October 2023, it was agreed that an updated deep dive review on Optimal Clinical Outcomes should be carried out.

This is provided separately for members' consideration at Appendix No. 2.

The updated deep dive was presented and discussed at EDG on the 15 February 2024 where the deep dive was accepted. However, it was agreed there would now be further

discussion through the Risks and Opportunities Group on whether it is appropriate to close the risk and develop a revised risk or risks.

Risk 9 - Quality and Safety

Following the Deep Dive review of the risk reported in July 2023, the Committee requested that the risk be revisited with a view to reducing the current risk score; this was given that the likelihood of occurrence was scored very high, despite the governance arrangements in place, and the number of completed mitigating actions.

A risk review was carried out which indicated the potential to reduce the risk level from high to moderate. Subsequently, it was agreed that the risk level should remain at high pending a review of governance arrangements. The Committee is advised that it is now possible to confirm the adequacy and effectiveness of the relevant governance arrangements. As a result, the current risk rating and level have been reduced from High 15 to Moderate 12 which brings the risk within its risk appetite of Moderate. Additionally, the risk target has been reduced from Moderate 10 to Low 6.

Details are provided in Appendix No. 1.

Potential New Corporate Risk: Pandemic Preparedness/Biological Threat

Preparation of a report and a Deep Dive Review on the above risk is underway. The Director of Public Health has requested that submission be deferred until the 3 May 2024 Committee meeting. In the interim, the items will be progressed through the Public Health Assurance Committee in February, and Executive Directors Group (EDG) in March/April. This will allow EDG to consider if they are supportive of the new risk being included on the Corporate Risk Register, and also to which committee it is best aligned.

Deep Dive Reviews

Risk Deep Dive reviews continue to be a key element of our assurance arrangements.

The requirement for a ‘deep dive’ will continue to be determined through routes including EDG and the Risks & Opportunities Group (ROG). Such decisions will be informed by intelligence within operational teams, as well as consideration of trigger factors such as the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk, as recommended in the update report to the January 2024 meeting of this Committee.

It is recognised that Committee Chairs may commission deep dive reviews for reasons other than the above. Such exceptions will be considered on a case by case basis.

The refreshed approach will be implemented during Quarter 2, 2024.

Work continues through the ROG to further develop the content of deep dive reviews in order that they enhance understanding, inform strategic thinking and help target and improve specific areas of risk.

Next Steps

The ROG will continue to promote and support the further development of risk management, and consider enhancements in this area. The Corporate Risk Register and Deep Dive Reviews, will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations.

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

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

Risk Appetite

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

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

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

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

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

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

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

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

- NHS Fife Clinical Governance Oversight Group on 13 February 2024
- Gemma Couser, Associate Director of Quality & Clinical Governance on 15 February 2024
- Alistair Graham, Associate Director of Digital & Information on 15 February 2024
- Neil McCormick, Director of Property & Asset Management on 15 February 2024
- Dr Chris McKenna, Medical Director, on 15 February 2024
- Dr Shirley- Anne Savage, Associate Director for Risk & Professional Standards on 15 February 2024
- Dr Joy Tomlinson, Director of Public Health on 15 February 2024

2.4 Recommendation

- **Assurance** - Members are asked to take a **"reasonable"** 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 No. 1, NHS Fife Corporate Risks aligned to the CGC as at 15/02/24
Appendix No. 2, Deep Dive Review: Optimal Clinical Outcomes
Appendix No. 3, Assurance Principles
Appendix No. 4, Risk Matrix

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

Updated NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as at 15 February 2024

To improve health and wellbeing

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (High)	Risk Owner
5	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below and related activities, to frame and plan our approach to meeting the challenges associated with this risk.	High 15 (L5xC3)	Mod 10 (L5xC2) by 31/03/24	◀▶	Within	Medical Director

		 The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time: Delivery of the Population Health & Well-being Strategy Delivery of the Recovery and Renewal Priorities Plan4Fife 2021-2024 Update Embedding of Anchor Institution Principles Continue the work of the Integrated Planned Care Programme Board (Chaired by the Director of Acute Services). Continue the work of Integrated Unscheduled Care Project Board (chaired by the Medical Director)					

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

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

To improve the quality of health and care services

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by Date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
9	**Quality & Safety** There is a risk that if our governance arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the Clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact.	Moderate 12 (L4 x C3)	Low 6 (L3 x C2) by 31/03/24	▲	Within	Medical Director

To deliver value and sustainability

	Risk	Mitigation	Current Risk Level / Rating	Target Risk Level & Rating by date	Current Risk Level Trend	Appetite (Moderate)	Risk Owner
16	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing with an indicative date of 31/12/23. Health Facilities Scotland (HFS) has agreed the design and the unit at St Andrews Community Hospital (SACH); the timescale to become operational has been revised from December 2023 to possibly June 2024. Work is underway to meet this target. An option appraisal for delivery of the service is being explored. Ensure that mitigations are in place to ensure that no trays are damaged while they are handled and stored in NHS Fife to include new racking and training Staff have received training in the safe handling of trays. Training is being repeated on a yearly basis. Staff must inspect each tray prior to loading on to storage system. New racking system installed early	Mod 12 (L4xC3)	Low 6 (L2xC3) by 01/04/2026 at next SG funding review	◄►	Within	Director of Property & Asset Management

		March 2022 costing £27,000 and prevents the stacking of trays. Tins purchased in early 2022 costing £29,000 in use to protect our heavy trauma and orthopaedic trays A trial of foam corners has been instigated by Tayside. Ensure that contingency stock has been procured to mitigate the effects of any down-time on the service to include: - •At least 3 Days of Trauma trays •At least 3 days of obstetric trays Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays. Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely manner. Regular Liaison meetings to discuss issues with the service have been taking place since 2021 Discussions are taking place about changing some of the terms in the SLA to allow defective trays to be identified at point of use rather than at point of delivery (July 2023) Considering alternative providers to determine whether value for money is					

		being provided and whether increased resilience can be provided.(work has been undertaken by Theatres over the last 6 months.) Involvement and influencing the National group looking at capacity and resilience in CDU provision across Scotland. This group, facilitated by National Services Scotland (NSS) will make recommendations to the Scottish Government (SG) about how best to increase capacity and resilience within NHS Scotland. This Group was convened in 2021. Work with Regional partners to identify synergies in service delivery including the developing business plan for re-provision of CDU capacity within NHS Lothian Raise the profile of this issue at National Estates and Facilities Fora including National Strategic Facilities Group which includes key representatives from NSS and SG					

17	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the previous year. The action plan for improvement has been presented to the Information Governance and Security Steering Group. The Deep Dive review for this risk was presented to Clinical Governance Committee in January 2024. Management actions detailed continue to be progressed.	High 16 (L4xC4)	Mod12 (L4xC3) by Sept 2024	◄►	Above	Medical Director
18	**Digital & Information (D&I)** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the current digital programmes against current strategic objectives is complete and has governed by the Digital and Information Board. The annual delivery plan for 2024/25 will demonstrate a reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue) The revised strategy will include, financial and workforce planning, to support the mitigation of this risk. D&I Board have established new	High 15 (L3xC5)	Mod 8 (L2xC4) by April 2025	◄►	Above	Medical Director

		prioritisation and authorisation processes with ongoing review. ongoing review.					

Risk Movement Key

▲ Improved - Risk Decreased

◄► No Change

▼ Deteriorated - Risk Increased

Deep Dive Review on Corporate Risk 5 - Optimal Clinical Outcomes March 2024

Corporate Risk Title	**Optimal Clinical Outcomes**		
Strategic Priority	To improve health and wellbeing		
Risk Appetite	HIGH		
Risk Description	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.		
Root Cause (s)	• COVID -19 related disruption • Demand exceeding capacity • Stepping down of some non-urgent services • Cost-of-living crisis The COVID 19 pandemic has directly impacted the health of individual citizens, healthcare staff and the ability of the healthcare system to deliver core services to the population.		
Management Actions (current)			
Current Risk Rating ([LxC] & Level (e.g. High Moderate, Low)	**Likelihood - 5**	**Consequence - 3**	**Level -** High
Target Risk Rating([LxC] & Level (e.g. High, Moderate, Low)	**Likelihood - 5**	**Consequence - 2**	**Level -** Moderate

Action	Status	Impact on Likelihood/ Consequence
Delivery of the Population Health & Well-being Strategy. The Population Health & Well-being Strategy was published in April 2023. Delivering Care to the people of Fife while fully acknowledging the challenges and designing services to respond to these challenges. This strategy sets out to prioritise health inequalities and support improvement in the health and wellbeing of our citizens. Through annual delivery plans, the implementation of the strategy will be taken forward in the context of a range of drivers for change. Recovery from the pandemic and aligning with the NHS Scotland Recovery Plan is included within the strategy. The strategy refers to the likely impact of the cost-of-living crisis and references the Public Health Scotland publication Population health impacts of the rising cost of living in Scotland (Dec 2022).	On Track – ongoing	Reduced Consequence
Delivery of the Recovery and Renewal Priorities Plan4Fife 2021-2024 Update The plan sets out key recovery and renewal priorities to be reflected in plans and strategies across the Health & Social Care Partnership (H&SCP).	On Track – ongoing	Reduced Consequence

The three key priorities for recovery and renewal were identified, all supported by an overarching approach of community wealth building: • Leading economic recovery • Tackling poverty and preventing crisis • Addressing the climate emergency		
Embedding of Anchor Institution Principles As a large organisation connected to our local area and community, we recognise we can make a positive contribution as an anchor institution. NHS Fife can influence the health and wellbeing of people in Fife simply by being there and by investing in and working locally and responsibly with others, we can have an even greater impact on the wider factors that make us healthy. NHS Fife Board has submitted a draft Anchor Institution Strategic plan to the Scottish Government. The strategy builds on the work already underway and will continue working more closely with communities and building on their existing strengths and assets. Baseline metrics have now been agreed by Scottish Government and Fife will be completing these prior to finalising the Anchors strategic plan (March 2024).	On Track – ongoing	Reduced Consequence
Continue the work of the Integrated Planned Care Programme Board (Chaired by the Director of Acute Services). • Focus on waiting times and supporting people, where appropriate, to wait well for their procedure • Further develop our day surgery service at Queen Margaret Hospital • Increase the level of ambulatory services across Fife • Continue to invest in and develop new technologies such as robot assisted surgery to provide high quality care • Provide a world class elective orthopaedic service through the National Treatment Centre – Fife Orthopaedics	Significant level of delivery challenge	Reduced Consequence
Continue the work of Integrated Unscheduled Care Programme Board (chaired by the Director of Health & Social Care and Director of Acute Services) with regular reporting through the Executive Directors' Group. • Reduce attendances – Redesign of Urgent Care • Flow Navigation Centre improvements • Reduce Admissions – Alternatives to Inpatient Care • Development of new pathways • Reduce Length of Stay – Rapid Assessment and Streaming • Support early decision making • Optimise Flow to align discharges and admissions patterns • Effective Discharge Planning	Significant level of delivery challenge	Reduced Consequence
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). The purpose of this group is to ensure the routine operation of	On Track – ongoing	Reduced Consequence

Cancer Services in NHS Fife Acute Services Division is managed effectively. It provides assurance and highlights any exceptions to performance, waiting times, and quality standards and systems resilience.		
Continue to develop and implement Annual Delivery Plans for the Cancer Framework. Optimal pathways and integrated care are included in the framework along with considering Cancer Waiting Times targets as a minimum standard. The Cancer Framework delivery plans for 2022/23 and 2023/24 are complete. The Effective Cancer Management Framework Action plan was agreed both locally and by Scottish Government and actions identified and implementation underway. The Rapid Cancer Diagnosis Service (RCDS) was established in June 2021 and is now supporting a rapid diagnostic pathway for patients with vague or concerning symptoms. A Single Point of Contact Hub (SPOCH) was implemented in September 2022, initially piloting centralised support for urological and bowel cancers and now extended to other specialties. SPOCH aims to improve patient experience by providing a central contact point for contact for patients going through a cancer pathway. This supports patient experience and also helps with early identification of potential delays before they are picked up at the patient tracking meeting.	On Track – ongoing	Reduced Consequence
Continue the work of the Primary Care Strategy Group. The Primary Care Strategy Group reports into the Public Health and Wellbeing Committee and is chaired by the Medical Director and Director of Health & Social Care. It oversees the development of the strategy and delivery plan and provides assurance to the Clinical Governance Committee for oversight. The Fife Primary Care Strategy 2023 – 2026 focuses on the recovery of primary care (post COVID-19 Pandemic), improving quality and making services more sustainable to achieve the strategic ambition to have a resilient and thriving primary care at the heart of an integrated health and social care system. This system will support the delivery of excellent, high quality, accessible and sustainable services for the population of Fife. Development of this primary care strategy supports a collaborative whole systems approach across NHS Fife and Fife H&SCP to provide services that are safe and accessible and reflect the needs and demands of the population. The strategy focuses on recovery, quality, and sustainability to improve outcomes for individuals, local communities and to reduce health inequalities.	On Track – ongoing	Reduced Consequence
Continue work on the Mental Health Redesign Programme The Mental Health Redesign Programme's aim is to ensure that there is access to the right level of care and treatment for people with mental health problems, which meet the needs of our communities. The priority is to improve the current in-patient	Significant level of delivery challenge	Reduced Consequence

facilities and work is underway, however, the business case for the new inpatient facility has been suspended by the Scottish Government as capital funds are not available.		
Continue the work of the Scheduled Care Group There are fortnightly meetings of the Scheduled Care Group to monitor and review waiting times for urgent and long waiting patients and agree actions to improve within current resources. Includes implementation of patient-initiated review (PIR) toward increasing clinic capacity for reviews and Active Clinical Referral Triage (ACRT) for reducing new appointment waiting lists. There is also work ongoing looking at Theatre Utilisation and maximisation of day surgery procedures.	On Track – ongoing	Reduced Consequence
Review the Scottish Government (SG) Value Based Health & Care. A Vision for Scotland, December 2022 document against our local plans. Scotland's vision is that by 2025, we will support the Health and Social Care workforce to practice Realistic Medicine (RM), thereby enabling the delivery of high-quality, personalised care to the people of Scotland. To improve our understanding of the unique context of Fife and empower staff to practice Realistic Medicine (RM) and Value Based Health and Care (VBHC), a RM Governance workshop took place on 20th September 2023 to explore how RM and VBHC can be embedded in Fife. The workshop used a World Café method which allowed participants to consider a range of topics from multiple perspectives and to make new connections. The workshop aimed establish governance arrangements for embedding RM in the organisation, to ensure the value of different Realistic Medicine projects is shared and identify ways to encourage staff to overtly use RM principles in their practice.	On Track – ongoing	Reduced Consequence
Continue escalation of issues through Senior Leadership Teams to Executive Director's Group then through to Clinical Governance Committee (and other committees as appropriate).	On Track - Ongoing	Reduced Consequence
Continue to implement the Fife H&SCP Strategic Plan for Fife 2023-26 The plan sets out the vision and future direction of the IJB's health and social care services. This includes how the nine National Health and Wellbeing Outcomes for Health and Social Care will be delivered locally, along with the six Public Health Priorities for Scotland. The Strategic Plan 2023 to 2026 is supported by the following transformational strategies. • Commissioning Strategy • Digital Strategy • Risk Management Strategy • Local Housing Strategy • Medium Term Financial Strategy • Workforce Strategy • Participation and Engagement Strategy	On Track – ongoing	Reduced Consequence
Implement the Cancer Framework Delivery Plan 2024/25	On Track	Reduced

		Consequence
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	On Track	Reduced Consequence
Anchor ambitions will be delivered over longer-term and will positively contribute to population health. The focus of this first strategic plan is on procurement, land and assets and employment. Service design and delivery and exemplar/system ambitions will be addressed as a second stage.	Not started	Reduced Consequence

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

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

Assurance Principles

General Questions:

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

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

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

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

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

Risk Assessment Matrix

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

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

Figure 1 Likelihood Definitions

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

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

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

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

Figure 2 Risk Matrix

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

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

Figure 3 Consequence Definitions

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

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

ASSURANCE SUMMARY
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
13th FEBRUARY 2023

1. Purpose

1.1 To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 13th February 2024. This assurance statement summarises the key aspects of business covered.

2. Matters Arising

2.1 An SBAR was presented following the escalation of increased incidences reported for unavailability of Urgent Care Mental Health Assessment Team (UCAT) Compliance to provide assurance that work was underway to mitigate the risks and service delivery challenges outlined previously by the corporate adverse events team via NHS Fife CGOG.

There were 2 key elements with regard to developments to improve the service:

- To assure members of the ongoing work to build and sustain optimal service capacity and delivery within the mental health Urgent Care & Assessment Team (UCAT).
- To provide assurance on the programme of improvement, delivered through the MHUUC Project team, to benchmark the current model of care and develop the service in order to best respond to the needs of the Fife population and within the resources available.

Two suggestions were made, firstly to capture the medical staffing issues as well as nursing and secondly to involvement of the Adverse Events Team early on in the process.

3. Governance

3.1 Draft Annual Statement of Assurance for Clinical Governance Oversight Group (CGOG)

The Annual Statement of Assurance was presented and comments sought. The statement includes the annual questionnaire inviting comment on the effectiveness of the CGOG. One of the main things in the feedback was the quantity of items on the agenda. An attempt has been made to address this and keep the meeting to time by adding timings to the agenda and seeking comments on papers prior to the meeting.

3.2 NHS Fife Annual Organisational Duty of Candour Annual Report 2022/2023

There were 33 adverse events requiring DoC with the most common outcome, for 24 patients, being an increase in a person's treatment.

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified including notifying the person and providing details of the incident, provision of an apology, reviewing all cases and offering support and assistance. There was Improvement since last year on providing the patient with a written apology.

There was one area identified for improvement and that was arranging a meeting following an offer to meet.

The Annual Organisational Duty of Candour Report was noted by the group with no comments made.

3.3 Fife Partnership Review of Children and Young People's Deaths - Annual Report

A decision had been taken to change to fiscal year reporting in line with other board reports and the National Hub and this will now be reported to the August meeting.

3.4 NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update

The group were updated on the Fife HSCP Quality Matters Assurance Group Clinical Quality (QMAG) meeting on 1st December and an overview of the 3 Quality Matters Assurance Safety Huddles (QMASH) held between 6th October and 1st December.

Assurance was given on the following:
Internal Audit Service Report (Risks 10 and 11)
Chid Protection Quarterly Report

3.5 NHS Fife Acute Services Division Clinical Governance Assurance Update

There is ongoing work to streamline the Acute Services CGC committee to make it as relevant as possible. The vision is for the three directorates to hold as much governance as possible at their local level. The Chairs of the committee have committed to spending time with each of the three Directorates to try and improve the work of clinical governance within the Division. The following were highlighted:

- Significant increase in critical incidents reported in September and October for ECD with concern raised about the number of incidents needing investigated and difficulty getting engagement in some areas to do the work due to other pressures.
- Significant fall in the percentage of patients being admitted to hospital within 4 hours (49.3% in 2022 vs 88% in 2021).
- Slight fall in completion of Comprehensive Geriatric Assessment within 3 days.
- Scottish Hip Fracture Audit showed rising incidence of hip fractures.
- Scottish Arthroplasty project showed a rise in number of procedures in hip and knee replacements bringing them almost back to pre-pandemic level with the independent sector being the largest provider for the first time.
- Significant increase in number of incidents reported in PCD with 297 reports, 64 of which involved harm. There was a significant impact of falls and tissue viability incidents within PCD come from National Treatment Centre (NTC. This is new for the directorate. This is mostly due to frailty and a planned Deep Dive is being completed to see if there are any common themes.
- Most of the actions from the MBRRACE (Mothers & Babies: Reducing Risk through Audits and Confidential Enquiries) follow up report have been implemented. There was an improvement in the Neonatal mortality and cooling rates in 2022.
- There have been 4 babies cooled in 2023, and a cluster review has been commissioned to examine any commonality.

3.6 NHS Fife Acute Services Division Health Improvement Scotland Inspection Update August 2023

This inspection resulted in four areas of good practice, two recommendations and nine requirements. The inspectors noted that the staff they spoke to felt supported and listened to and that staff were responsive to patients' needs. Serious concerns were raised about the condition of the healthcare-built environment, Phase 1 which was noted to be in very poor condition. Concern was also raised about the oversight, communication, and escalation processes in relation to the condition of the environment.

A comprehensive action plan has been agreed by NHS Fife, which was accepted by the HIS Inspection team.

Oversight arrangements to ensure timely progress and to support governance assurance is via Acute Services Division (ASD) governance structures into NHS Fife's Corporate Governance was agreed.

3.7 NHS Fife Clinical Policy & Procedure Update December 2023

The group were given assurance that there was a 99% compliance rate for all clinical policies and procedures for NHS Fife.

It was advised at the 18th December 2023 meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that there were **two** policies made obsolete:

- DC-U-01 - NHS Fife Wide Staff Dress Code and Uniform Policy – moved to HR Policies and Procedures
- C-01 – NHS Fife Wide Policy for Child Protection - Unborn Child – superseded by a new fife wide procedure.

There are **two** Fife wide procedures past their review date:

- FWP-HP-01 - NHS Fife Wide Adult In-patient Hydration Procedure (08/10/2023). This will be reviewed and returned to the group.
- FWP-BBMHB-01 Fife Wide Procedure for Babies Born to Mothers with Hepatitis B Infection and/or Babies Born into a household where a member (other than the mother) is known to be infected with Hepatitis B (01/04/2023). Comments have been received from Dr Helen Botherton for reviewer to update procedure and bring back to the group.

3.8 NHS Fife Activity Tracker
The **activity tracker** was shared with the group, there was nothing **new** to note.

3.9 NHS Fife Scottish Health Technology Group Update

In April 2023, a process was designed in order to ensure that NHS Fife meets the requirement for NHS Boards to consider the advice produced by SHTG and that the appropriate governance is in place. The process requires that each report is reviewed and documented through an audit trail.

Since the start of the process:-

- 24 reports have been through the process (18 assessments and 6 recommendations)
- 18 reviews have been completed (13 assessments and 5 recommendations)
- 6 reviews are currently outstanding (2 are in the process of being escalated)

3.10 Review of Draft NHS Fife Clinical Governance Oversight Group Annual Workplan 2024/25

This was noted by the group and will be shared with the membership prior to April's meeting for any comments.

4. NHS Fife Corporate Risk

4.1 Further to the last report to this Group, the Director of Public Health confirmed to the CGC on 12 January 2024, that the Covid-19 risk had achieved and surpassed its risk target, and that reviews over a period of time showed the risk had remained stable. A closing Deep Dive review and supporting SBAR set out the management actions in place, and the rationale to support closing the risk on the Corporate Risk Register and managing it as business as usual. The Committee took assurance on the Deep Dive and agreed on the recommendation to close as a Corporate Risk and transfer oversight to the Public Health Assurance Committee.

There had been a lot of discussion at CGC around the 'Quality & Safety' risk,
The risk review indicated the potential to reduce the risk level from high to moderate. Subsequently it was agreed that the risk level should remain at high pending a review of governance arrangements related to quality, safety and organisational leaning. The Group is advised that it is now possible to confirm the adequacy and effectiveness of our governance arrangements. It is therefore recommended to proceed with the proposed reduction in the current risk level and rating from High 15 to Moderate l2. If agreed, this would bring the risk within its risk appetite of Moderate.

With regards to potential Corporate Risks, the Director of Public Health and colleagues are preparing a new risk to be considered for inclusion on the Corporate Risk Register which will address wider threats to the healthcare system such as pandemic preparedness/biological threats. This will be presented to the CGC in May 2024.

PC concluded by informing the group that, working with their colleagues within the NHS Fife Risks & Opportunities Group, the process around commissioning deep dives was being refined and triggers were being reviewed going forward. Also, how the content of deep dives could be enhanced, any updates would be brought to CGOG in due course.

5. Adverse Events Update

5.1 NHS Fife Adverse Events KPI's

There were still significant overdue SAER's and LAER's, however, in December the action rate of 'closure on time' was 50%, hopefully this good work could continue and raise the rate further.

5.2 NHS Fife Adverse Events Themes & Trends Report

Overall, 16,981 incidents reported in 2023, an increase on the 16, 653 reported in 2022. The top 5 reported incident categories remains consistent across the year, with unwanted behaviours, violence and aggression accounting for 21% of all reported incidents.

There has been an increase in unwanted behaviours, violence and aggression incidents which equate to 50% of the overall increase in reports in comparison to 2022 (3266 reported in 2022, 3429 reported in 2023). Further interrogation of the data shows the increase is consistently across the year in the subcategory of physical assault on staff. Four incidents were reported as severity major/extreme compared with 1 in 2022.

This rise in incidences of violence and aggression was acknowledged and information to come back to the April meeting to provide some assurance around how those incidents are being reported and managed throughout our Governance system.

From the clinical governance matrix there had been 2 trigger list workshops to redefine the structure of reporting and what should be reported as major and extreme events. Both workshops were very well attended across the organisation. A paper will be brought to April's meeting to describe the outcome of these meetings and propose options on how best to define, report and manage major/extreme events going forward.

A suggestion was made to review and streamline the process for adverse events and focus on the consistency and the learning.

5.3 NHS Fife Adverse Events Flashcard

This was noted by the group.

6. Patient Experience

6.1 NHS Fife Patient Experience Flashcard

The flashcard with the group pointing out that the total number of complaints, concerns and enquiries was 2070, 554 were stage 1 and 336 were stage 2 complaints. It was worth noting the number of concerns (467) and enquiries (713) as these were often unseen work of the Patient Experience Team (PET).

The themes of complaints were consistent throughout the year:

- Disagreement with treatment / care plan
- Co-ordination of clinical care & treatment
- Staff attitude
- Poor nursing care
- Communication

7. Strategy and Planning

7.1 NHS Fife Clinical Governance Strategic Framework Annual Delivery Plan 2023/2024

The annual delivery plan for 2023/2024 to look back on the year as well as a proposed plan for 2024/2025 will be presented to the April meeting.

7.2 NEWS2

The project group was now established, and work was underway with the clinical team to start to look at the specification of NEWS2. A more informed update will bew provided at the April meeting.

The group were asked to consider, under the current financial circumstances, whether NEWS2 was still required.

8. Linked Meeting Minutes and Escalations

There were no escalations from the linked meeting minutes.

9. AOCB

8.1 Date of next meeting 16th April 2024

Appendix 1 – Attendance

Member	Designation	13th Feb 2024
Lynn Barker	Associate Director of Nursing, Health Social Care Partnership	✓
Norma Beveridge	Interim Associate Director of Nursing, Acute	✓
Dr Sue Blair	Consultant in Occupational Medicine	x
Andy Brown	Principal Auditor - Finance	x
Gemma Couser	Associate Director of Quality & Clinical Governance	✓
Pauline Cumming	Risk Manager	✓
Fiona Forrest	Deputy Director of Pharmacy & Medicines	✓
Claire Fulton	Adverse Events Lead	✓
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP	✓
Robyn Gunn	Head of Laboratory Services	✓
Ben Hannan	Director of Pharmacy and Medicines	x
Dr Helen Hellewell	Associate Medical Director, HSCP	✓
Janette Keenan	Director of Nursing	x
Aileen Lawrie	Associate Director of Midwifery	✓
Dr Sally McCormack	Associate Medical Director for Emergency Care & Planned Care	x
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	✓
Dr Iain MacLeod	Deputy Medical Director, Acute	✓
Siobhan McIlroy	Head of Patient Experience	x
John Morrice	Associate Medical Director for Women and Children's Services	x
Elizabeth Muir	NHS Fife Clinical Effectiveness Manager	✓
Sally O'Brien	Head of Nursing	x
Victoria Robb	Lead Pharmacist, Medicines Safety	x
Nicola Robertson	Assistant Director of Nursing, Corporate Division	x
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance	✓
Prof Morwenna Wood	Director of Medical Education	x
Amanda Wong	Associate Director of Allied Health Professionals	✓
In Attendance	**Designation**	
Lee Cowie	Senior Manager, H&SCP, Child/Adult Mental Health & Addiction Services	✓
Lizzie Gray	Patient Experience Team Lead	✓
Kate Gaunt	Deteriorating Patient & Resuscitation Lead	✓
April Robertson	Clinical Governance Administrator (Minute Taker)	✓

DRAFT CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2024 / 2025

Governance - General							
	Lead	**03/05/24**	**08/07/24**	**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**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Governance Matters							
	Lead	**03/05/24**	**08/07/24**	**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, CGOG, ICC)	**Board Secretary**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
CGOG 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**	✓ **Biological Threats**	✓	✓	✓	✓	✓
Review of Terms of Reference	**Board Secretary**						✓ Approval
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval

Strategy / Planning							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Advanced Practitioners Review Update	**Director of Nursing**			✓			
Annual Delivery Plan Quarterly Performance Report 2024/25 *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓ **Q4**	✓ **Q1**		✓ **Q2**		✓ **Q3**
Cancer Strategic Framework & Delivery Plan	**Medical Director/Associate Director for Risk and Professional Standards**				✓		
Clinical Governance & Strategic Framework Delivery Plan 2023/24	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
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**	**08/07/24**	**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**	✓	✓	✓	✓	✓	✓
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**			✓			
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					

Digital / Information							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Digital and Information Strategy 2019-24 Update	**Medical Director / Associate Director of Digital & Information**		✓		✓		
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**03/05/24**	**08/07/24**	**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**	✓					
Annual Reports / Other Reports							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Adult Support & Protection Annual Report 2020-22 *(also goes to PHWC)*	**Director of Nursing**		✓				
Allied Health Professional Assurance Framework	**Director of Nursing**			✓ **Update**			
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**			✓			
Fife Child Protection Annual Report 2023/24 *(also goes to PHWC)*	**Director of Nursing**		✓				

Annual Reports / Other Reports (cont.)							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
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 Safety Review and Improvement Report 2023/24	**Director of Pharmacy & Medicines**				✓		
Occupational Health Annual Report 2023/24	**Director of Workforce**			✓			
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**	✓					
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**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Area Clinical Forum	**Chair of Forum**	04/04	06/06	01/08	03/10	05/12	06/02
Area Medical Committee	**Medical Director**	13/02	09/04	11/06	13/08	08/10	10/12
Area Radiation Protection Committee	**Medical Director**	TBC					
Cancer Governance & Strategy Group	**Medical Director**	21/03	30/05	-	15/08	-	31/10
Clinical Governance Oversight Group	**Medical Director**	13/02	16/04	18/06	20/08	22/10	10/12

Linked Committee Minutes (cont.)							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Digital & Information Board	**Medical Director**	-	23/04	23/07	-	15/10	-
Fife Area Drugs & Therapeutic Committee	**Medical Director**	07/02	17/04	19/06	21/08	23/10	18/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**	08/03	10/05	05/07	04/09	08/11	10/01
Health & Safety Subcommittee	**Chair of Subcommittee**	08/03	07/06	-	06/09	06/12	-
Infection Control Committee	**Director of Nursing**	07/02	03/04	05/06	07/08	02/10	04/12
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**	Ad-hoc					
Information Governance & Security Steering Group	**Director of Finance & Strategy**	16/04 – **deferred (date tbc)**	-	17/07	-	21/10	29/01
Medical Devices Group	**Medical Director**	13/05	12/06	-	11/09	11/12	-
Research, Innovation & Knowledge Oversight Group	**Medical Director**	-	23/05	-	-	14/11	-
Resilience Forum	**Director of Public Health**	13/03	-	13/06	11/09	12/12	-
Ad-hoc Items							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Matters Arising							
	Lead	**03/05/24**	**08/07/24**	**06/09/24**	**04/11/24**	**06/01/25**	**07/03/25**
Development Sessions							
	Lead						

CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2023 / 2024

Governance - General							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Health Improvement Scotland (HIS) Inspection Update	**Director of Nursing**			✓			
Computerised Tomography (CT) Scanner Update and Next Steps	**Director of Acute Services**			✓			
Letter to Cabinet Secretary re. Countess of Chester Hospital Inquiry	**Medical Director**				✓		
Letter from Chief Medical Officer re. Report of the Transvaginal Mesh Case Record Review	**Medical Director**				✓		
Reinforced Autoclaved Aerated Concrete	**Director of Property & Asset Management**					✓	
Notification to Health & Safety Executive (HSE) of Work in Atmosphere Containing Radon	**Medical Director**					✓	
Governance Matters							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Assurance Statements from Subcommittees (D&I Board, H&S Subcommittee, IG&S Steering Group, IJB Q&C Committee, Resilience Forum, Medical Devices)	**Board Secretary**	✓					

Governance Matters (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Annual Statement of Assurance for Clinical Governance Oversight Group	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Summary from Aug '23 mtg**	✓ **Summary from Oct '23 & Dec' 23 mtgs**	✓ **Summary from Feb '24**
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC, and Deep Dives	**Medical Director/Director of Nursing**	✓ **Optimal Clinical Outcomes**	✓ **Quality & Safety**	✓ **Off-Site Area Sterilisation and Disinfection Unit Service**	✓ **Digital & Information**	✓ **Covid-19 and Cyber Resilience**	✓ **Optimal Clinical Outcomes**
Review of Terms of Reference	**Board Secretary**						✓ Approval
Delivery of Annual Workplan 2023/24	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓
Review of Annual Workplan 2024/25	**Associate Director of Quality & Clinical Governance**					✓ Draft	✓ Approval
Strategy / Planning							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Advanced Practitioners Review	**Director of Nursing**	✓					
Annual Delivery Plan Quarterly Performance Report 2023/24 *(also goes to FP&R, PH&W & SGC)*	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Deferred to July**	✓	✓	✓ **Q2**		**Q3 Report removed – not required by SG**
Cancer Strategic Framework & Delivery Plan	**Medical Director**				✓		

Strategy / Planning (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Clinical Governance & Strategic Framework Delivery Plan 2023/24	**Medical Director / Associate Director of Quality & Clinical Governance**	**Deferred to July**	✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓					
Data Loch	**Medical Director**	**Removed from workplan - this item is being replaced, and once ready, will be brought back**					
Development Assistant Practitioner Role	**Director of Nursing**	✓					
Integrated Unscheduled Care	**Medical Director**	✓					
Quality / Performance							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Breast Screening Adverse Event Paper	**Director of Public Health**		**Removed – July PHWC only**				
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
National Cervical Exclusion Audit	**Director of Public Health**		**Removed – covered at PHWC in May**				
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**	**2 yearly report – due September 2024**					
Hospital Acquired Covid Report	**Medical Director**					**Deferred to next mtg**	✓ **Private Session**
Digital / Information							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Digital and Information Strategy 2019-24 Update	**Medical Director / Associate Director of Digital & Information**		✓		✓		
Laboratory Information Management System Update	**Associate Director of Digital & Information**			✓ **Private Session**			

Digital / Information (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓ **Private Session**			✓
Information Governance and Security Steering Group Update	**Associate Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Equalities Outcome Report *(also goes to PHWC)*	**Director of Nursing**						**Due 2025**
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Annual Reports / Other Reports							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Adult Support & Protection Annual Report 2020-22 *(also goes to PHWC)*	**Director of Nursing**	✓					
Allied Health Professional Assurance Framework	**Director of Nursing**	**Deferred to July**	**Deferred to Sept.**	✓			
Annual Resilience Report 2022/23	**Director of Public Health**	**Partial Assurance Statement**			✓ **Mid-year Assurance Report**	**Annual Assurance Statement will be provided in May 2024**	
Clinical Advisory Panel Annual Report 2022/23	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report August 2023	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2023 *(also goes to PHWC)*	**Director of Public Health**		✓				
Equality Outcomes Progress Report 2021-25	**Director of Nursing**	**Presented in 2023, and will be next presented in 2025, along with the 2026-29 report**					

Annual Reports / Other Reports (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Fife Child Protection Annual Report 2022/23 *(also goes to PHWC)*	**Director of Nursing**	**Deferred to July**	✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report 2022/23	**Medical Director**				✓		
Integrated Screening Annual Report	**Director of Public Health**	**Will be presented to the Public Health & Wellbeing Committee only**					
Medical Education Annual Report 2022/23	**Medical Director**				**Deferred to January**	**Deferred to March**	✓
Medical Appraisal and Revalidation Annual Report 2022/23	**Medical Director**				**Deferred to January**	✓	
Occupational Health Annual Report 2022/23	**Director of Workforce**			✓			
Organisational Duty of Candour Annual Report 2022/23	**Medical Director**						✓
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation 2022/23	**Director of Nursing**				**Deferred to January**	✓	
Prevention & Control of Infection Annual Report 2022/23	**Director of Nursing**				✓		
Radiation Protection Annual Report 2022/23	**Medical Director**	✓					
Research & Development Progress Report & Strategy Review 2023-25	**Medical Director**					✓ **Noted**	✓ **For assurance**
Research, Innovation and Knowledge Annual Report 2022/23	**Medical Director**					✓ **Noted**	✓ **For assurance**
Review of Deaths of Children & Young People	**Director of Nursing**						**Deferred to August**
Volunteering Annual Report 2022/23	**Director of Nursing**				✓		
Linked Committee Minutes							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Clinical Forum	**Chair of Forum**	06/04 **Mtg Cancelled**	✓ 08/06	✓ 03/08	✓ 05/10	✓ 07/12	✓ 08/02

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Area Medical Committee	**Medical Director**	✓ 14/02	✓ ~~11/04~~ 02/05	✓ ~~13/06~~ 27/06	✓ 08/08	✓ 10/10	✓ 12/12
Area Radiation Protection Committee	**Medical Director**	✓ 31/08	-	-	✓ 10/05	✓ 14/11	✓ 12/12
Cancer Governance & Strategy Group	**Medical Director**	✓ 30/03	✓ 31/05	-	✓ 17/08	✓ 02/11	✓ 11/01
Clinical Governance Oversight Group	**Medical Director**	✓ 14/02	✓ 18/04	✓ 20/06	✓ 22/08	✓ 24/10 & 12/12	✓ 13/02
Digital & Information Board	**Medical Director**	✓ 19/04	-	✓ 19/07	-	✓ 19/10	-
Fife Area Drugs & Therapeutic Committee	**Medical Director**	-	✓ 26/04	✓ 21/06	✓ 16/08	21/10 **Mtg Cancelled**	✓ 20/12 & 07/02
Fife IJB Quality & Communities Committee	**Associate Medical Director**	✓ 10/03	-	✓ 03/05	✓ 30/06 & 07/09	✓ 02/11	✓ 17/01
Health & Safety Subcommittee	**Chair of Subcommittee**	✓ 10/03	✓ 09/06	-	✓ 08/09	✓ 08/12	-
Infection Control Committee	**Director of Nursing**	✓ 05/04	✓ 07/06	-	✓ 09/08 & 04/10	✓ 06/12	-
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**	**Ad hoc – no meetings in 2023/24**					
Information Governance & Security Steering Group	**Director of Finance & Strategy**	✓ 11/04	-	✓ 13/07	-	✓ 10/10	-
Medical Devices Group	**Medical Director**	✓ 08/03	-	✓ 14/06	✓ 13/09	13/12 **Mtg Cancelled**	-

Linked Committee Minutes (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Research, Innovation & Knowledge Oversight Group	**Medical Director**	✓ 27/03	-	✓ 21/06	✓ 19/09	✓ 11/12	-
Resilience Forum	**Director of Public Health**	✓ 01/03	-	✓ 08/06	07/10 **rescheduled to 10/10**	✓ 10/10	✓ 07/12
Ad Hoc Items							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Mental Health Estates Initial Agreement	**Medical Director**	**Deferred on 5 May, 7 July & 3 November, due to financial constraints. Initial Agreement is part of a larger business plan for mental health. Removed from workplan.**					
Medical Devices	**Director of Property & Asset Management**	✓					
Public Protection, Accountability & Assurance Framework	**Director of Nursing**	✓					
Fatal Accident Enquiry	**Medical Director**	✓	✓				
Excellence in Care Presentation	**Director of Nursing**		✓				
Infection Control Inspection by Health Improvement Scotland Report	**Director of Nursing**		✓				
Medical Devices Update	**Medical Director**	**Ad Hoc – no update for 2023/24**					
Deteriorating Patient Cardiac Arrest Update	**Director of Nursing**			✓			
Incident Management Framework	**Director of Public Health**				✓		
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
The Infection Prevention Workforce: Strategic Plan 2022-24	**Director of Nursing**			✓			
Care Opinion Report	**Director of Nursing**			✓			
High Risk Pain Medicines - Patient Safety Programme, End of Year 1 Report	**Director of Pharmacy & Medicines**			✓			
Medicines Safety Review and Improvement Report	**Director of Pharmacy & Medicines**				✓		

Ad Hoc Items (cont.)							
	Lead	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/23**	**12/01/24**	**01/03/24**
Alignment of NHS Fife Cancer Framework and the National Cancer Strategy 2023-2033 and Cancer Action Plan for Scotland 2023-2026	**Medical Director**				✓		
Medical Appraisal and Revalidation Framework	**Medical Director**					✓	
Internal Controls Evaluation Report 2022/23	**Director of Finance & Strategy**					✓	
Strategy Mid-Year Review	**Director of Finance & Strategy**					✓	
Patient Story	**Director of Nursing**					✓	✓
Alignment of NHS Fife Realistic Medicines / Value Based Health and Care Delivery Plan and the Scottish Government Value Based Health and Care Action Plan	**Associate Director of Quality & Clinical Governance**						✓
Safe Delivery of Care Inspection and Learning Review - Victoria Hospital from 31 July 2023 to 2 August 2023	**Director of Nursing**						✓

Development Sessions							
	Lead						
Development Session 1 • Medical Education • Addiction Services	**Medical Director**	**12/04/23**					
Development Session 2 • Research relationship between NHS Fife and the University of St Andrews.	**Medical Director**			**18/10/23**			
Development Session 3 • Optimal Clinical Outcomes	**Medical Director**			**23/10/23**			
Development Session 4 • Excellence in Care	**Medical Director**					**12/03/24**	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Planning & Performance Manager**

1 Purpose

This is presented for:

- Assurance
- Discussion

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report informs the Clinical Governance (CG) Committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is generally up to the end of December, although there are some measures with a significant time lag.

2.2 Background

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

We have now transitioned to the Annual Delivery Plan for 2023/24. Improvement actions have been included in the IPQR: statuses for these actions are being collated and will be included in the IPQR and redistributed prior to going to the Committees. This streamlines

local reporting for governance purposes with quarterly national reporting to the Scottish Government.

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

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

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

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

2.3 Assessment

Performance has been hugely affected during the pandemic. To support recovery, NHS Fife is progressing the targets and aims of the 2023/24 Annual Delivery Plan (ADP), which was submitted to the Scottish Government at the end of July 2023. New targets have been devised for 2023/24.

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

Measure	Update	Local/National Target	Current Status
Adverse Events [1]	Monthly	50%	Achieving
HSMR	Quarterly	1.00 (Scotland average)	Below Scottish average
Falls [2]	Monthly	6.95 per 1,000 TOBD	Not achieving
Pressure Ulcers [2]	Monthly	0.89 per 1,000 TOBD	Not achieving
SAB (HAI/HCAI)	Monthly	18.8 per 100,000 TOBD	Achieving
ECB (HAI/HCAI)	Monthly	33.0 per 100,000 TOBD	Achieving
C Diff (HAI/HCAI)	Monthly	6.5 per 100,000 TOBD	Achieving
Complaints (S1)	Monthly	80%	Not achieving
Complaints (S2) [3]	Monthly	33%	Not achieving

[1] Reporting on the closure rate of actions from Major & Extreme Adverse Events started in December 2022

[2] As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2023/24. These are a 15% reduction on the FY 2021/22 target for Falls, and a 20% reduction on the actual achievement in FY 2022/23 for Pressure Ulcers.

[3] An improvement target of 50% by March 2023, rising to 65% by March 2024 was agreed by the Director of Nursing. However, performance has been very much lower than the 50% provisional target, generally due to closing long-term complaints. A further measure (Stage 2 Complaints Raised in Month and Closed Within 20 Working Days) has been added.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

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

Not applicable.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

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

The Clinical Governance extract of the Position at January IPQR will be available for discussion at the meeting on 01 March 2024.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG on 26 February 2024 and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The report is being presented to the CG Committee for:

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

3 List of appendices

- Appendix 1 – Integrated Performance & Quality Report

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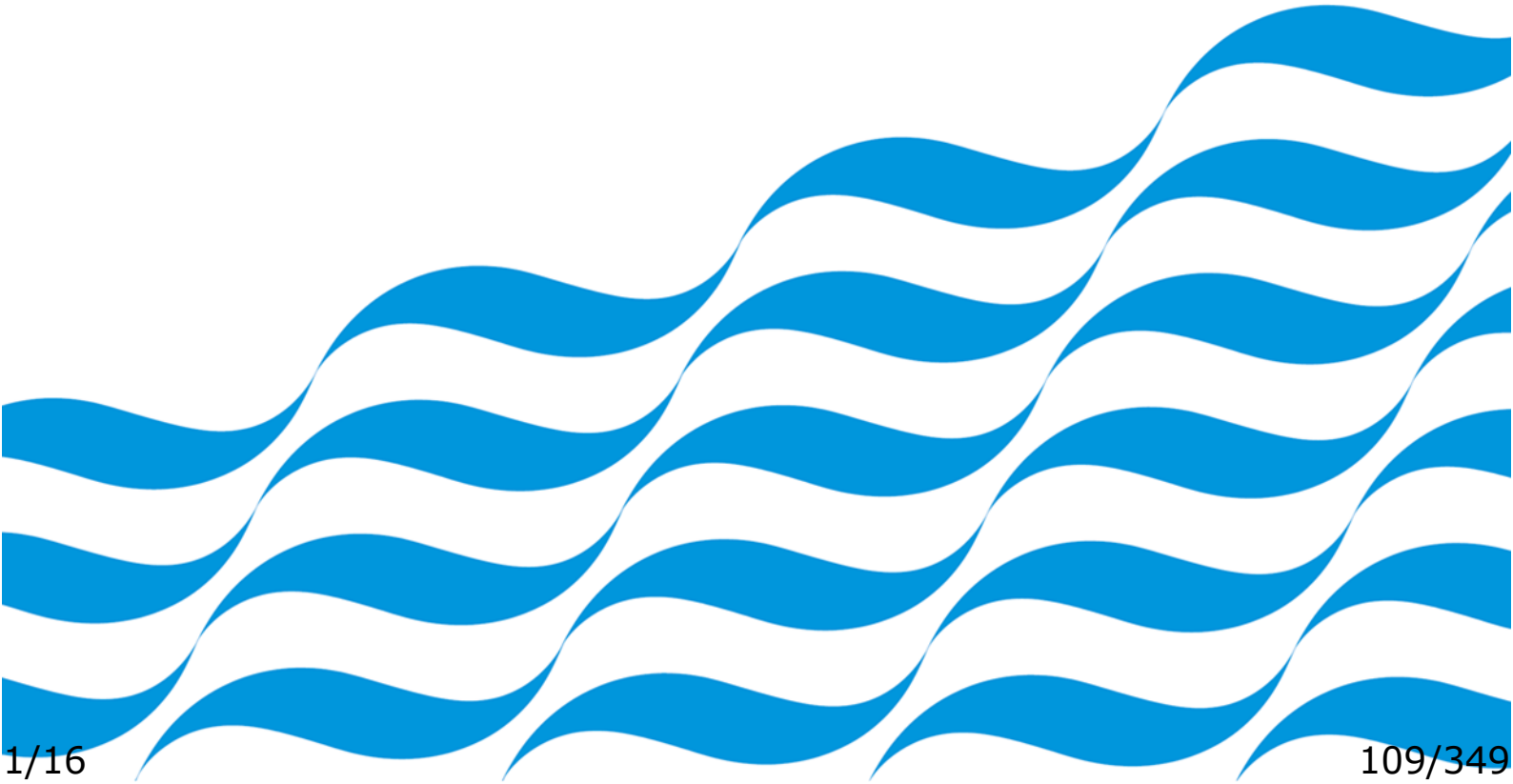
Fife Integrated Performance & Quality Report

CLINICAL GOVERNANCE

Position (where applicable) at January 2024
Produced in February 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).

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

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

The IPQR comprises the following sections:

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

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

c. **Projected & Actual Activity**
   Comparing projected Scheduled Care activity to actuals.

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

e. **Performance Exception Reports**
   Further detail for indicators of focus or concern. Includes additional data presented in tables and charts, incorporating SPC methodology, where applicable. Deliverables, detailed within Annual Delivery Plan (ADP) 2023/24, relevant to indicators are incorporated accordingly.

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

MARGO MCGURK
Director of Finance & Strategy
12 February 2024

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

a. Corporate Risk Summary

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◀ ▶	High
To improve the quality of health and care services	6	5	1	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	**18**	**13**	**5**	**0**	**0**		

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 Increase

Summary Statement on Risk Profile

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

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

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

b. Indicator Summary

Section	Indicator	Target 2023/24 2023/24 TBC		Reporting Period	Current Period	Current Performance	SPC Outlier	Vs Previous	Vs Year Previous	Benchmarking	
Clinical Governance	Major/Extreme Adverse Events - Number Reported	N/A	-	Month	Dec-23	48	○	▲	▼	●	
	Major/Extreme Adverse Events - % Actions Closed on Time	50%		Month	Dec-23	50.0%	●	▲	▲	●	
	HSMR	N/A	-	Year Ending	Jun-23	0.96	●	–	–	●	
	Inpatient Falls	6.95	(L)	Month	Dec-23	7.10	○	▼	▲	●	
	Inpatient Falls with Harm	1.44	(L)	Month	Dec-23	1.42	○	▲	▲	●	
	Pressure Ulcers	0.89	(L)	Month	Dec-23	1.28	○	▼	▼	●	
	SAB - HAI/HCAI	18.8	(N)	Month	Dec-23	6.6	○	▲	▼	●	QE Jun-23
	C Diff - HAI/HCAI	6.5	(N)	Month	Dec-23	3.3	○	▼	▲	●	QE Jun-23
	ECB - HAI/HCAI	33.0	(N)	Month	Dec-23	29.7	○	▲	▼	●	QE Jun-23
	S1 Complaints Closed in Month on Time	80%		Month	Dec-23	43.9%	●	▼	▼	●	2021/22
	S2 Complaints Closed in Month on Time	33%		Month	Dec-23	8.0%	○	▼	▼	●	2021/22
	S2 Complaints Due in Month and Closed On Time	N/A	-	Month	Dec-23	5.9%	●	▼	▼	●	
Operational Performance	IVF Treatment Waiting Times	90%		Month	Sep-23	100.0%	●	◀▶	◀▶	●	
	4-Hour Emergency Access (A&E)	95%	(N)	Month	Jan-24	71.5%	○	▲	▲	●	Dec-23
	4-Hour Emergency Access (ED)	82.5%	(L)	Month	Jan-24	64.6%	●	▲	▲	●	Dec-23
	Patient TTG % <= 12 Weeks	100%		Month	Dec-23	37.5%	●	▼	▼	●	Sep-23
	New Outpatients % <= 12 Weeks	95%		Month	Dec-23	38.2%	●	▼	▼	●	Sep-23
	Diagnostics % <= 6 Weeks	100%		Month	Dec-23	43.9%	●	▼	▼	●	Sep-23
	Cancer 31-Day DTT	95%		Month	Dec-23	92.5%	○	▼	▼	●	QE Sep-23
	Cancer 62-Day RTT	95%		Month	Dec-23	71.2%	○	▲	▲	●	QE Sep-23
	Freedom of Information Requests	85%		Month	Jan-24	91.7%	●	▲	▲	●	
	Delayed Discharge % Bed Days Lost (All)	N/A	-	Month	Jan-24	10.5%	●	▲	▼	●	Dec-23
	Delayed Discharge % Bed Days Lost (Standard)	5%		Month	Jan-24	5.9%	○	▲	▼	●	Dec-23
	Antenatal Access	80%		Quarter	Sep-23	92.1%	●	▼	▼	●	CY 2022
Finance	Revenue Resource Limit Performance	(£12.9m)	-	Month	Jan-24	(£12.2m)	●	–	–	●	
	Capital Resource Limit Performance	£11.3m	-	Month	Jan-24	£7.2m	●	–	–	●	
Staff Governance	Sickness Absence	4.00%		Month	Dec-23	7.80%	○	▼	▲	●	YE Sep-23
	Personal Development Plan & Review (PDPR)	80%	(L)	Month	Jan-24	41.6%	●	▼	▲	●	
	Vacancies - Medical & Dental	N/A		Quarter	Sep-23	9.4%	●	▲	▼	●	
	Vacancies - Nursing & Midwifery	N/A		Quarter	Sep-23	6.5%	●	▲	▼	●	
	Vacancies - AHPs	N/A		Quarter	Sep-23	8.0%	●	▲	▲	●	
Public Health & Wellbeing	Smoking Cessation (FY 2023/24)	473	(N)	YTD	Sep-23	93	●	–	–	●	YT Mar-23
	CAMHS Waiting Times	90%		Month	Dec-23	75.3%	○	▲	▲	●	QE Sep-23
	Psychological Therapies Waiting Times	90%		Month	Dec-23	75.5%	○	▲	▲	●	QE Sep-23
	Drugs & Alcohol Waiting Times	90%		Month	Oct-23	86.9%	●	▼	▼	●	QE Sep-23
	Flu Vaccination (Winter, Age 65+)	85%		Month	Jan-24	79.9%	●	▲	–	●	
	COVID Vaccination (Winter, Age 65+)	85%		Month	Jan-24	79.3%	●	▲	–	●	
	Immunisation: 6-in-1 at Age 12 Months	95%		Quarter	Sep-23	94.2%	○	▲	▼	●	QE Sep-23
	Immunisation: MMR2 at 5 Years	92%		Quarter	Sep-23	88.8%	○	▼	▲	●	QE Sep-23

Performance Key

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

SPC Key

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

Change Key

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

Benchmarking Key

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

c. Projected & Actual Activity and Long Waits

Better than Projected | Worse than Projected
Better/Worse may be higher or lower, depending on context

		Quarter End	Quarter End	Month End			Quarter End	Quarter End
		Jun-23	Sep-23	Oct-23	Nov-23	Dec-23	Dec-23	Mar-24
ED 4-hour Performance (VHK only)	Projected			70.0%	75.0%	75.0%		
	Actual			66.8%	66.6%	63.5%		
	Variance			-3.2%	-8.4%	-11.5%		
Elective Activity Diagnostics	Projected	15,363	15,363	5,121	5,121	5,121	15,363	15,363
	Actual	14,393	15,588	5,412	5,387	4,788	15,587	
	Variance	-970	225	291	266	-333	224	
Elective Activity New Outpatients	Projected	22,309	22,337	7,421	7,432	7,421	22,274	22,308
	Actual	21,225	21,580	7,090	7,985	6,046	21,121	
	Variance	-1,084	-757	-331	553	-1,375	-1,153	
Elective Activity TTG	Projected	3,416	3,433	1,162	1,162	1,163	3,487	3,492
	Actual	3,403	3,289	1,109	1,307	1,101	3,517	
	Variance	-13	-144	-53	145	-62	30	
Long Waits Diagnostics > 26 weeks	Projected	109	63	42	26	10	10	0
	Actual	171	165	160	150	204	204	
	Variance	62	102	118	124	194	194	
Long Waits New Outpatients > 104 weeks	Projected	0	74	120	166	212	212	352
	Actual	1	2	2	2	2	2	
	Variance	1	-72	-118	-164	-210	-210	
Long Waits New Outpatients > 78 weeks	Projected	150	339	509	679	849	849	1358
	Actual	85	255	301	336	336	336	
	Variance	-65	-84	-208	-343	-513	-513	
Long Waits TTG > 104 weeks	Projected	16	67	102	136	173	173	351
	Actual	20	17	25	40	32	32	
	Variance	4	-50	-77	-96	-141	-141	
Long Waits TTG > 78 weeks	Projected	159	305	388	465	547	547	893
	Actual	84	133	154	186	183	183	
	Variance	-75	-172	-234	-279	-364	-364	
Arthroplasty 4 joint sessions	Projected	25.0%	25.0%				25.0%	25.0%
	Actual	10.3%	16.9%	12.5%	10.9%	14.0%	12.4%	
	Variance	-14.7%	-8.1%				-12.6%	
Same Day Procedures Knee Arthroplasty	Projected	1.9%	1.9%				1.9%	1.9%
	Actual	4.1%						
	Variance	2.2%						
Same Day Procedures Hip Arthroplasty	Projected	4.3%	4.3%				4.3%	4.3%
	Actual	8.0%						
	Variance	3.7%						
Cancer Waiting Times 31-Day	Projected	93.8%	94.1%				94.3%	94.5%
	Actual	96.5%	92.5%	91.8%	95.0%	92.5%	93.1%	
	Variance	2.7%	-1.6%				-1.2%	
Cancer Waiting Times 62-Day	Projected	81.9%	82.8%				85.0%	85.4%
	Actual	77.5%	73.7%	86.6%	61.2%	71.2%	73.0%	
	Variance	-4.4%	-9.1%				-12.0%	
CAMHS 18 Weeks RTT	Projected			70.0%	70.0%	60.0%		
	Actual			67.9%	78.6%	73.8%		
	Variance			-2.1%	8.6%	13.8%		
CAMHS Waiting List <= 18 weeks	Projected	216	228	232	257	235	235	200
	Actual	224	197	184	187	180	180	
	Variance	8	-31	-48	-70	-55	-55	
CAMHS Waiting List > 18 weeks	Projected	116	98	77	86	42	42	0
	Actual	70	91	87	49	64	64	
	Variance	-46	-7	10	-37	22	22	
Psychological Therapies 18 Weeks RTT	Projected			69.3%	68.2%	71.0%		
	Actual			54.3%	56.5%	56.3%		
	Variance			-15.0%	-11.7%	-14.7%		
Psychological Therapies Waiting List <= 18 weeks	Projected	888	888	888	888	888	888	888
	Actual	1460	1480	1404	1412	1427		
	Variance	572	592	516	524	539		
Psychological Therapies Waiting List > 18 weeks	Projected	1660	1569	1609	1596	1680	1680	1604
	Actual	1173	1219	1184	1086	1109		
	Variance	-487	-350	-425	-510	-571		
Psychological Therapies Waiting List > 52 weeks	Projected	219	165	147	129	111	111	57
	Actual	273	251	278	276	263		
	Variance	54	86	131	147	152		

d. Assessment

CLINICAL GOVERNANCE

To improve the quality of health and care services

6	5	1	-	-	◄►	Moderate

		Target	Current
Major & Extreme Adverse Events	*50% of Action from Major and Extreme Adverse Events to be closed within time*	**50%**	**50.0%**

There were 16 actions relating to LAER/SAER closed on time in December 2023, from a total of 32, which equates to a performance of 50.0%: an increase on the 33.9% seen in November and an improvement on the 41.9% seen in December 2022. Target has been reached for the first time since July 2023.

There were 47 Major/Extreme adverse events reported in December out of a total of 1,439 incidents.

70.0% 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 (187) followed by 'Patient Fall' (68 incidents), and then 'Cardiac Arrest' (64 incidents).

On average, 50 actions have been closed per month in 2023 compared to 37 over the same period in 2022.

There were 355 actions open at the end of December, with 85 (23.9%) being within time.

Service Narrative

It was reported to Clinical Governance Oversight Group in December 2023 that there was consistent increase in incidents reported with severity recorded as major/extreme during 2023.

In the last 12 months, the average closure time for a LAER is 240 days and SAER is 313 days: target for both is 90 days. The increase in workload associated with managing a SAER/LAER (predominantly for clinical team) was thought to be contributing to the delay in completion and closure of SAERs/LAERs. A decision was taken to re-define a local trigger list, taking into consideration the National Framework for Learning from Adverse Events. Trigger list and local guidance will be produced to provide clearer advice on the event types and outcomes that should be reported within the major/extreme severity categories. This work will be completed at workshops with engagement across the organisation in Jan/Feb 2024 with approval through Clinical Governance Oversight Group and reflected in an updated adverse events policy in Spring 2024.

HSMR		**1.00**	**0.96**

(n.b. data is published quarterly so below is a repeat of the analysis in last month's IPQR)

Data for 2022 and 2023 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2023 showing a ratio below the Scottish average

Inpatient Falls	*Reduce **All Falls** (inpatient) rate by 15% in FY 2023/24 compared to baseline (YE Sep-21)*	**6.95**	**7.10**
	*Reduce **Falls with Harm** (inpatient) rate by 10% in FY 2023/24 compared to baseline (YE Sep-21)*	**1.44**	**1.42**

The number of inpatient falls in total was 205 in December 2023, up from 174 the month prior. This equates to a rate of 7.10 falls per 1,000 Occupied Bed Days (OBD). Performance is therefore outwith the target of < 6.95 but remains within control limits and is just below the 24-month average.

The number of inpatient Falls 'with Harm' was 41 in December, 5 less than the month prior, and this equates to a rate of 1.42 falls per 1,000 OBD: thus, performance achieved the target of < 1.44 for December.

The number of falls within Acute Services was 91 in December. This is 19 more than the month prior and equates to a rate of 6.82 per 1,000 OBD (compared to 5.35 in November).

The number of falls within HSCP was 114 in December, 12 more than the month prior and this equates to a rate of 7.35 per 1,000 OBD (compared to 6.91 in November).

The majority of falls in the last 3 months (75.4%) were classified as 'No Harm' whilst 18.9% were classified as 'Minor Harm' and 2% were classified as 'Moderate Harm'. Falls classified as 'Major/Extreme Harm' accounted for 3.7% of the total falls (compared to 4% for the preceding 3 months).

Service Narrative

The number of falls during November & December 2023 remains lower than the previous 2-month period with a slight increase in December to 7.10 per 1000 OBD. Falls with harm continue to decrease and remain on target at 1.42 per 1000 OBD. New one-to-one intensive supervision procedure was launched this week.

Pressure Ulcers	*Reduce pressure ulcer rate by 20% in FY 2023/24 compared to the rate in FY 2022/23*	**0.89**	**1.28**

The total number of pressure ulcers in December 2023 was 37, which was 2 more than the month previous. This equates to a rate of 1.28 per 1,000 Occupied Bed Days (OBD). Performance has therefore worsened, and PU rate remains beyond the target of < 0.89 but it remains within control limits.

The number of pressure ulcers in Acute Services was 32 in December, an increase of 4 on the previous month (24-month average is 24 and rate is 2.40).

The number of pressure ulcers in HSCP was 5 in December, a decrease of 2 on the previous month (24-month average is 7 and rate is 0.32).

Most pressure ulcers continue to be in Acute Services with 95 recorded between Oct-Dec 2023 compared with 20 in HSCP.

Of all Pressure Ulcers recorded in December 2023, Grade 2 accounted for 50% of the total; with Grades 3 & 4 accounting for 21%.

Service Narrative

he December incident of PU in both ASD and HSCP settings continues to be closely monitored. Both ASD and HSCP continue to have presence at a joint HSCP/ASD Tissue Viability group chaired by DoN. The review into both ASD/HSCP Tissue Viability teams and their scopes with a vision of one team being developed continues and the aim remains for completion March 2024. There is a planned event organised by the community teams to educate practitioners around available dressings for pressure ulcers and this has been shared widely across the partnership to encourage attendance. The HCSP have identified the need for further work on the prevention of PU and a further group is being stood up involving tissue viability and team leaders from district nursing to review cases and identify learning for sharing widely. Heads of Nursing posts in both ASD and HSCP have been filled, pressure ulcers are now aligned to the new postholders portfolios which will support ongoing improvement plans.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**18.8**	**6.6**

The SAB healthcare associated infection (HCAI) rate decreased from 13.4 in November 2023 to 6.6 in December, this is approximately double for the same month in 2022 (3.2).

Of the 47 HAI/HCAI reported in the last 12 months, 9 have been categorised as ‘VAD’ 10 have been categorised as ‘Other’ or ‘Not Known’ and 8 have been categorised as 'Device Other Than VAD'.

The cumulative number of SAB cases January to December 2023 (47) is lower than the same time period in 2022 (50). The Infection rate has remained below the national target for NHS Fife of 18.8 since April 2023.

Q3 2023 Quarterly Report showed Fife (9.2 per 100, 000 TOBDs) was below the national rate (18.1 per 100,000 TOBDs) for healthcare associated cases. Considering Q4 2023; there was an increase in the number of HCAI cases (10 cases in total), compared to during Q3 2023 (8 cases). We are currently awaiting the Q4 2023 National Report for comparison.

Service Narrative

There were 8 dialysis line related SABs during 2023. This was an increase, compared to 2 cases in 2022 and none in 2021. Renal services carried out a CCR of each case (Jan-Apr) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been Datix`d by the Consultant Microbiologist. Please note that, as of 01/01/2024, 133 days had been achieved since the last dialysis line related SAB.

Prior to a case in October, NHS Fife had achieved over a full year without a PVC related SAB. Also for highlighting, as of 01/01/2024, over 525 days have been achieved since the last CVC related SAB.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2024*	**6.5**	**3.3**

The HCAI CDI rate increased to 3.3 in December. However, this is significantly lower than December 2022 level of 13.0.

The cumulative total of CDI HCAI Jan 23 – Dec 23 at 33 is higher than during the same time period in 2022 at 30.

The number of recurring infections (4) has increased compared to the same period in 2022 (3), the number of non-recurring cases has also increased from 37 in 2022 to 43 in 2023.

Q3 2023 quarterly report showed Fife (4.6 per 100,000 TOBDs) was well below the national rate (15.5 per 100,000 TOBDs) for healthcare associated cases. Considering Q4 2023, there was a lower number of HCAI cases (n=2), compared to during Q3 2023 (4 cases in total). Currently awaiting National Report for board comparison.

Service Narrative

History of recent antibiotics (i.e. within the previous 12 weeks) remains the most frequently seen risk factor amongst cases. Antibiotic stewardship in helping to reduce CDIs in the Primary Care newsletter.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2024*	**33.0**	**29.7**

The number of HCAI infections decreased from 11 in November 2023 to 9 in December and the rate of infection decreased from 36.9 to 29.7 HAI/HCAI per 100,000 Occupied Bed Days (OBD).

The cumulative number of HCAI infections for the period January - December (113) is lower than the same period in 2022 (123).

Urinary Catheter related infections have been responsible for 29 of the 113 infections in the last year (25.6%) and remains a key focus for improvement work although the 'Not Known' category accounts for 24 infections (22.1%). You would have to state that the `not known` accounts for 26 (23%) of HCAI cases, otherwise the statement is misleading, as there were also some `unknown` CAI cases. Compared with the previous year the number of Urinary Catheter infections in HCAIs has decreased by 12.9%.

Q3 2023 quarterly report showed Fife (32.2 per 100,000 TOBDs) was lower than the national rate (37.8 per 100,000 TOBDs) for healthcare associated infection cases. However, Q4 2023 ECB cases, there was a higher number of HCAI cases (n=34), compared to during Q3 2023 (n=28). We are currently awaiting the National Report for comparison.

Service Narrative

The majority of ECBs occur in the community, and hepatobiliary and renal are the most common source of infection. It is reassuring to see that the number of CAUTI related ECBs have reduced over the past couple of years.

The Urinary Catheter Improvement Group continue to meet regularly, with the aim of establishing improvement work, to reduce CAUTIs. CAUTI insertion and maintenance bundles have been installed onto Patientrak and were trialled in V54. This is currently sitting with digital & information before rolled out across the board.

Each CAUTI related ECB is Datixed and undergoes a CCR. Monthly CCR meetings continue to take place to explore and discuss recent CAUTI cases.

Complaints	*At least 33% of Stage 2 complaints will be completed within 20 working days by March 2024*	**33%**	**8%**

There were 44 stage 1 complaints received in December, with 42 closed. Of those closed 45.2% were within timescales.

With 4 greater than 40 days after due date, 11 of which were closed between 6 and 20 days. 49 complaints were due to be closed in the month, 21 (42.9%) of which were closed on time.

10.7% of live complaints have been open for more than 41 days with 53.6% open for between 6 and 40 days.

75% of live complaints are awaiting statements an increase from 59% November.

The total number of open Stage 1 in December was 27 this equates to an increase of 107.6% from November (13) and an increase of 35% from April 2023 (20)

There were 14 stage 2 complaints received in December, with 100% acknowledged within timescales, with 25 closed. Of those closed 8% were within timescales.

With 18 greater than 40 days after due date, 6 of which were closed greater than 80 days after due date. 17 complaints were due to be closed in the month,1 (5.9%) of which were closed on time.

66.2% of live complaints have been open for more than 40 days with 46.5% open for more than 80 days and 8.5% open for more than 160 days. Both the over 40 days and over 80 days open complaints have increased in December.

23.9% of live complaints are awaiting statements with 43.7% awaiting approval of final response the latter having increased from 37.2% in November.

The total number of open Stage 2 Complaints continues to trend downwards in December was 71 this equates to a decrease of 17.5% from November (86) and a decrease of 52.6% from April 2023 (150)

Service Narrative

There is an ongoing focus on stage 1 complaints to encourage the Service to contact the complainant directly, reducing the need for Patient Experience to send a written response. Changes were made to the Stage 1 statement memo encouraging Services to contact the complainant directly, and this was tested within the Emergency Care Directorate, with a plan to roll out to other areas in the new year.

The PET has 1.8 WTE Support Officers that process the Stage 1 complaints and all the enquiries and concerns. In December 2023, there were also between 35-45 open concerns and 30-40 open enquiries, predominantly handled by the Band 4 PET Support Officers, allowing the Band 6 PET Officers to focus on the Stage 2 complaints. Services and PET were also encouraged to communicate more directly to facilitate quicker responses and highlight potential issues or delays with responding to the Stage 1s.

Historically, NHS Fife had timeframe complaints of 80% of Stage 1 complaints to be answered with the 5-day target or 10-day extended timeframe. The 80% timeframe compliance target has only been achieved once between December 2022 and December 2023.

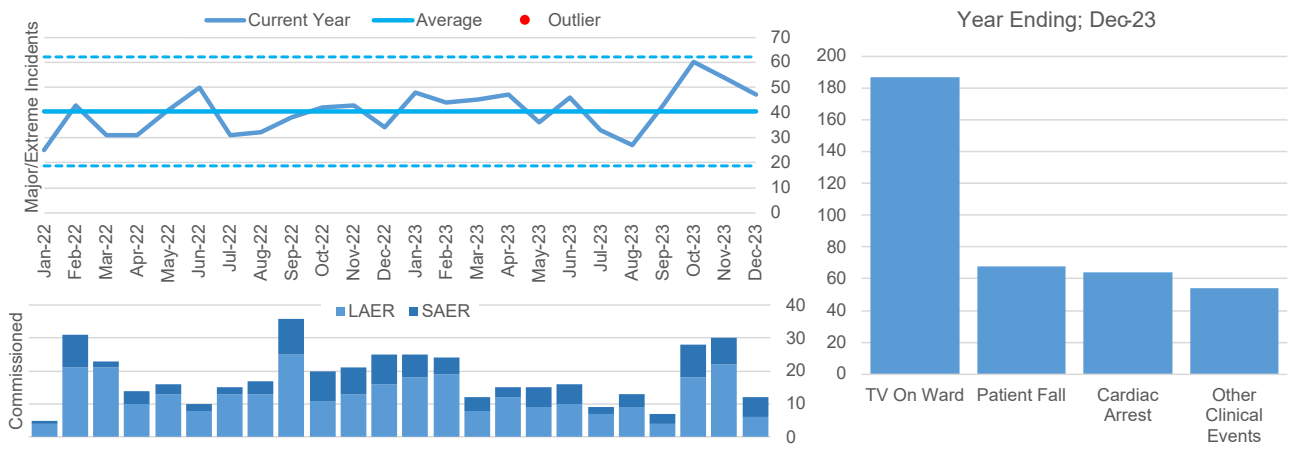
The new complexity scoring categorisation has been applied to every Stage 2 complaint, providing insight into the volume of complex complaints that NHS Fife receives and handles. The complexity categorisation has changed from complex and non-complex to negligible, minor, moderate, major and extreme. The first draft of this scoring categorisation has been shared with Senior Leaders across NHS Fife for comment and feedback. At the end of December 2023, 0 negligible, 10 minor, 48 moderate, 21 major, and 1 extreme stage 2 complaints were open.

The Complaints Dashboard was launched in November 2023, providing up-to-date data regarding open enquiries, concerns, and Stage 1 and 2 complaints. A new weekly report was created and shared with Services weekly, using screen grabs of the Dashboard data and providing a live link to the MicroStrategy page, raising awareness and accessibility of the Complaints Dashboard. The data on the Complaints Dashboard is pulled from Datix and refreshed daily. The new weekly report also shows the previous 2 months data compliance for Stage 1 and Stage 2 complaints.

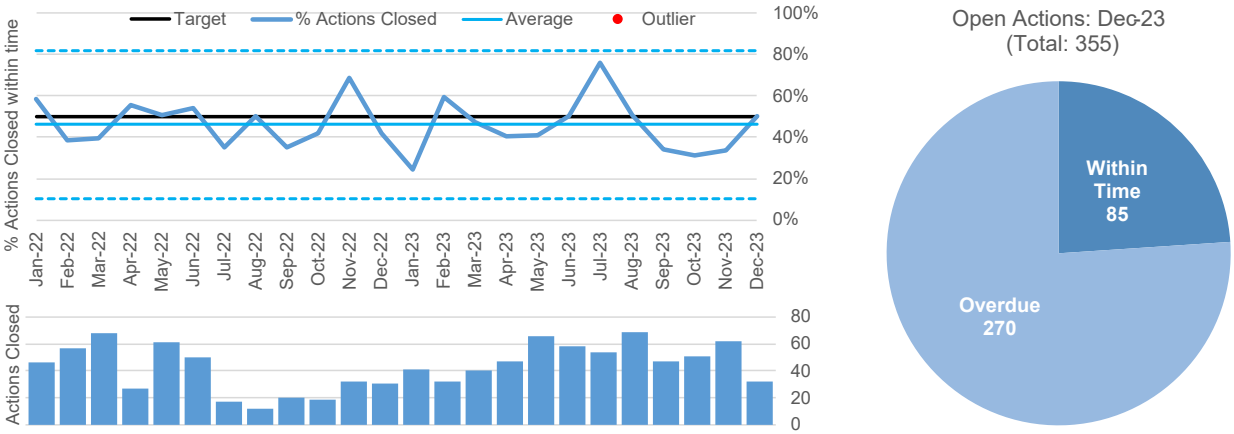
At the end of October 2023, there were 111 Stage 2 complaints. This decreased to 80 at the end of December 2023. There was previously a backlog of complaints to be drafted, but with the additional support of 0.42 WTE Band 6 PET Officer and a reduction in sickness absence by the end of December, there were only 9 complaints (12.5%) being or awaiting drafting and only one Stage 2 requiring PET action. Stage 2 complaints awaiting statements or comment/approval within the Services was 81%. At the end of October 2023, there was 1 Stage 2 complaint at 330 days and 8 over 200 days. This improved, and by the end of December 2023, there were only 2 Stage 2 complaints over 200 days.

e. Performance Exception Reports

Adverse Events	Number 47



Actions from Significant and Local Adverse Event Reviews	Closure Rate 50.0%



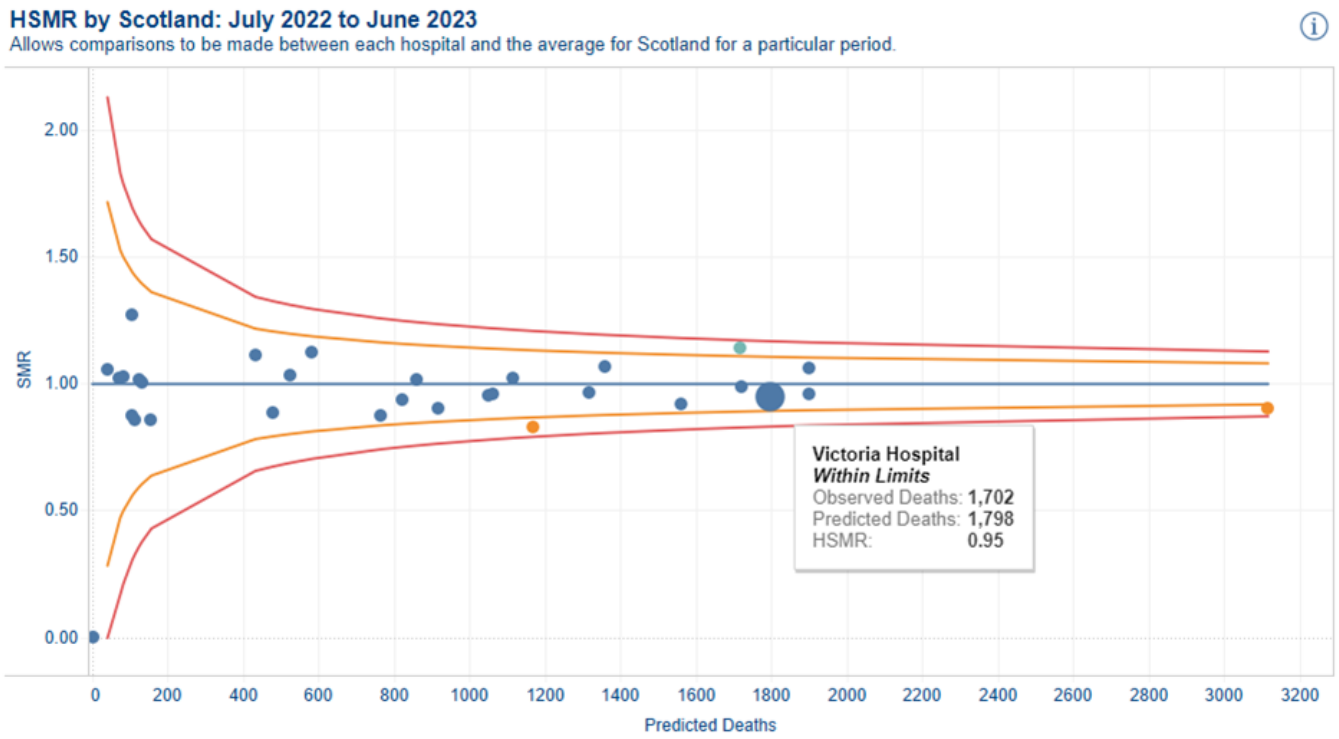
Key Deliverable	End Date
Off track / At risk / On track / Complete / Suspended	Proposed
Delivery of Clinical Governance Strategic Framework - Adverse Events	Mar-24
Key Milestones: Publication of updated Adverse Events Policy	Apr-23
Key Milestones: Adverse Events Management Resource Pack uploaded to Blink	Dec-23
Key Milestones: Deliver bespoke training session, where requested, to complement the e-learning package for review teams	Aug-23
Key Milestones: Facilitate short life working group to identify changes required to Datix action module	Mar-24
Key Milestones: Review and refresh of Datix Action Module to support improvement to the theming of action types to enhance identification and inform on themes of learning	Apr-24
Key Milestones: Implementation of updated Adverse Events policy and related procedures	Jan-24

HSMR *Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.* ***(n.b. data is published quarterly so below is a repeat of the information reported in last month's IPQR)***	**Performance 0.96**

Reporting Period: July 2022 to June 2023

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

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



Commentary

Data for 2022 and 2023 demonstrates a return to a typical ratio for NHS Fife, with the data for year ending June 2023 showing a ratio below the Scottish average

Inpatient Falls

All Falls

Reduce All Falls rate across Acute & HSCP by 15% Target Rate (by end March 2024) = 6.95 per 1,000 Occupied Bed Days (OBD)

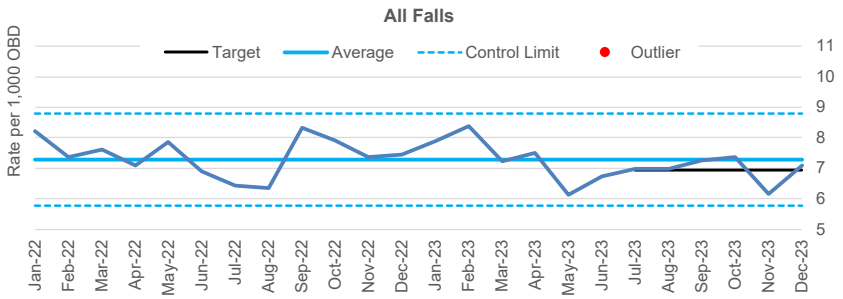
Performance 7.10

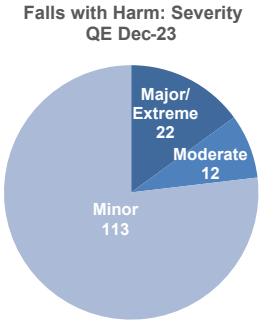
Falls with Harm

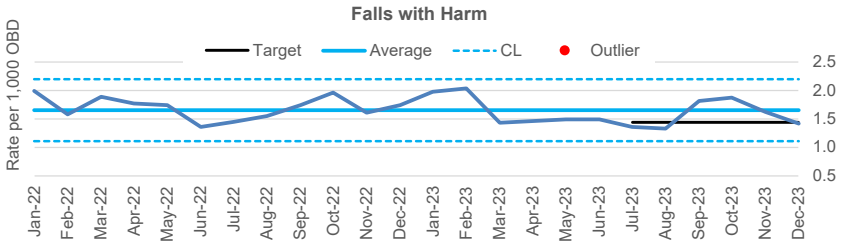
Reduce Falls with Harm rate across Acute & HSCP by 10% Target Rate (by end March 2024) = 1.44 per 1,000 Occupied Bed Days (OBD)

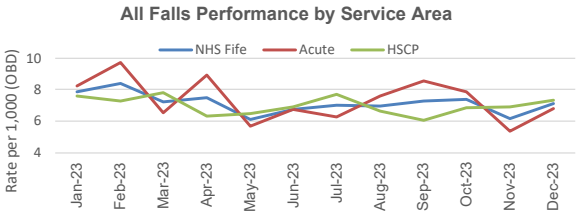
Performance 1.42

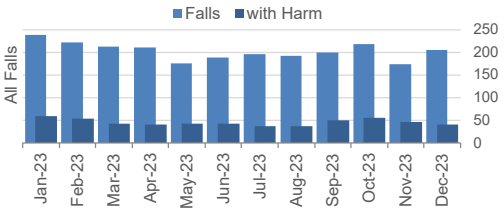
Local Performance











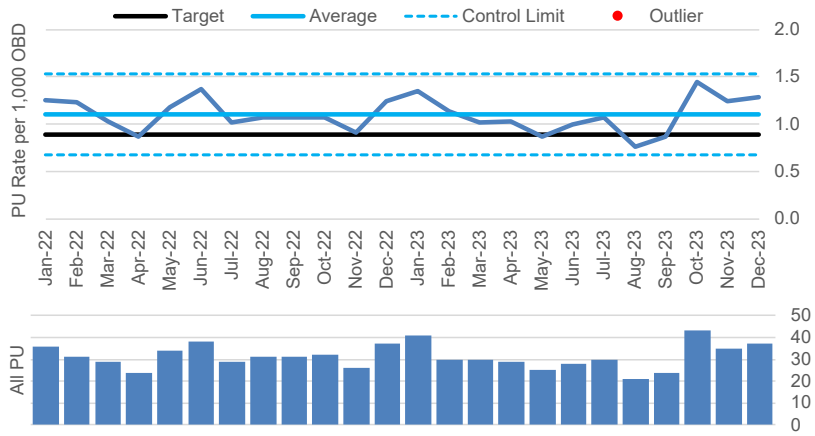
Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Reduce Falls across all hospital inpatient setting		**Jun-24**
Key Milestones	Review and confirm falls link practitioners for each ward area on every hospital site	Mar-24
	Ensure that falls related data is discussed and displayed in the ward to strengthen awareness across multi-disciplinary team	Apr-24
	Rollout revised Falls toolkit including related policies e.g.: Boarding, Supervision, Bed rail	Mar-24
	Support shared learning from incidents and share good practice	Dec-23
	Align all NHS work with the newly updated SPSP National Inpatient Falls driver diagrams	Feb-24
	Develop a national Falls education module within TURAS system	Jun-24
	Rollout new patient information leaflet and endeavour to audit the impact and benefit for patients	Apr-24
	Consider a Falls Co-ordinator Role to support the rollout of the revised toolkit and the Link Practitioners	Mar-24

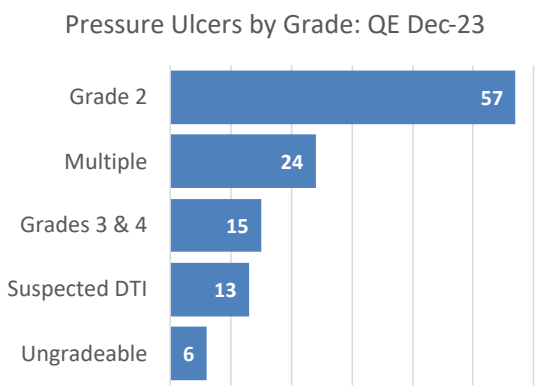
Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting
Target Rate (by end March 2024) = 0.89 per 1,000 OBD

Performance 1.28

Local Performance





Performance by Service Area

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
NHS Fife	1.35	1.13	1.02	1.03	0.87	1.00	1.07	0.76	0.87	1.44	1.24	1.28
Acute	2.39	2.33	1.82	1.48	1.44	1.43	1.95	1.45	1.61	2.44	2.08	2.40
HSCP	0.44	0.14	0.37	0.65	0.38	0.66	0.39	0.20	0.21	0.52	0.47	0.32

Key Deliverable	End Date
Off track / At risk / On track / Complete / Suspended	Proposed
Reduce Pressure Ulcers (PU) developed on case load across all health care settings	**Mar-24**
Key Milestones: Acute TVNT - Provide training to over 1000 staff	Mar-24
Acute TVNT - Re-launch the service (updating service spec, training resources, TVN link programme)	Jul-23
Embed the use of the CAIR resource	Mar-24
Embed the revised HIS Pressure Ulcer Standards (October 2020)	Mar-24
Review of services and options for new service design	Mar-24

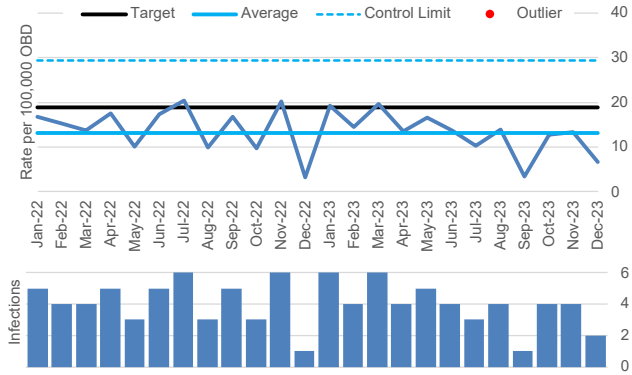
HAI/HCAI

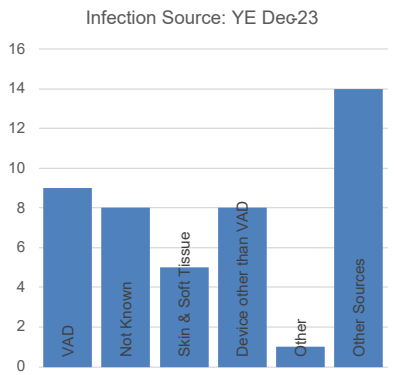
SAB

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 6.6

Local Performance





National Benchmarking

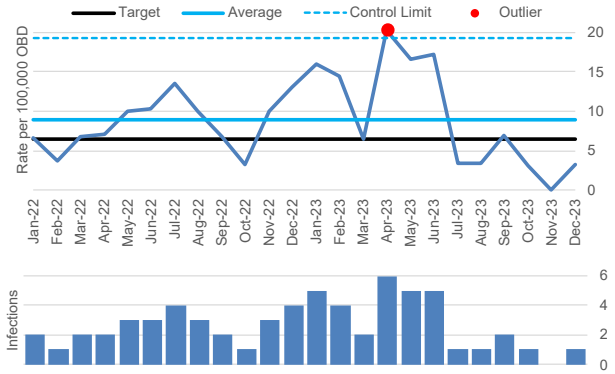
Quarter Ending	2020/21	2021/22				2022/23			
	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	16.6	12.7	15.2	14.9	15.7	10.9	17.9	14.6	9.2
Scotland	18.3	17.3	16.3	17.3	17.1	19.2	19.1	18.3	18.1

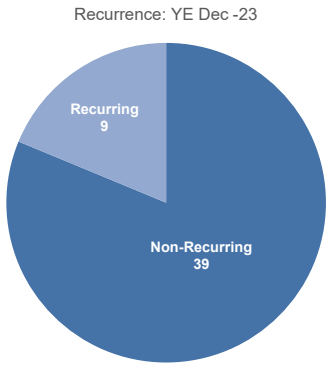
C Diff

Reduce Hospital Infection Rate by 10% (baseline 2018/19) by the end of 2022/23

Performance 3.3

Local Performance





National Benchmarking

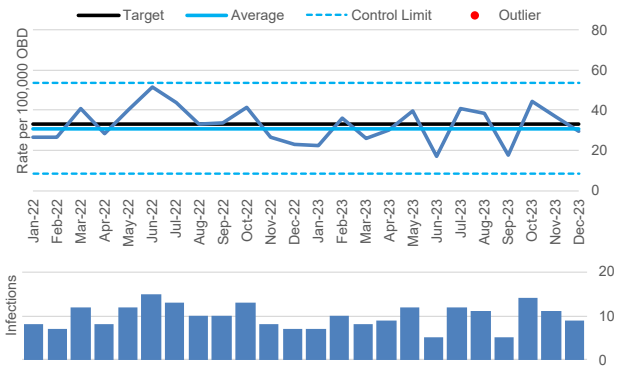
Quarter Ending	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22	Dec-22	Mar-23	Jun-23	Sep-23
NHS Fife	9.5	4.6	7.0	9.2	10.1	8.7	13.4	18.0	4.6
Scotland	16.8	13.3	12.6	14.3	13.1	13.6	13.4	16.1	15.5

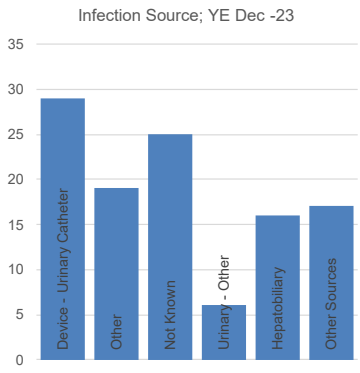
ECB

Reduce Hospital Infection Rate by 25% (baseline 2018/19) by the end of 2022/23

Performance 29.7

Local Performance





National Benchmarking

Quarter Ending	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22	Dec-22	Mar-23	Jun-23	Sep-23
NHS Fife	60.3	33.6	31.6	40.2	36.9	30.4	27.9	29.3	32.2
Scotland	41.5	34.1	30.5	34.8	36.2	34.5	37.3	37.6	37.8

Key Deliverable		End Date
Off track / At risk / On track / Complete / Suspended		Proposed
Implement IPC Workforce Strategy 2022-24		**Sep-24**
Key Milestones	Complete a GAP analysis of the NHS Fife IPCT with regards to recommendations for local Boards	Apr-23
	Awaiting updates to national deliverables which are currently delayed. Recommendations 1, 9, 10,12, 14 and 15	Mar-24
	Engage with other key stakeholders outlined in the strategic plan (HPT and AMR) to begin discussions to determine roles and remits	Nov-23
	Oversight Board shall include an options appraisal of models of support for Primary Care and strategic plan developed. Including a subgroup, with collaboration with all key stakeholders (GP and Dental)	Mar-24
	Delivery date of September 2023 - SG to lead on discussions to improve quality and coverage of national - level workforce data for a functional IPC programme at the national and facility level	Mar-24
	Business case for additional resources and funding to be developed for consideration and Board approval	Mar-24
	Final implementation paper to be presented to February 2024 ICC	Feb-24
Implement IPC Interim Strategy 2023-25		Apr-25
Committed to controlling, reducing and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) in order to maintain individual safety within our healthcare settings.		Apr-24
Key Milestones	Aim for the pilot of the eCatheter insertion and maintenance bundle to have been completed and plan for role out to other areas in NHS Fife	Mar-24
	Complete QI project with D&I to improve data capture of ePVC	Mar-24
	Support roll-out of eCatheter insertion and maintenance bundles	Mar-24

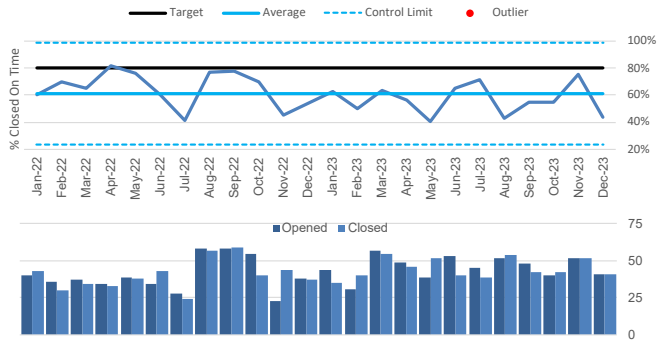
Complaints

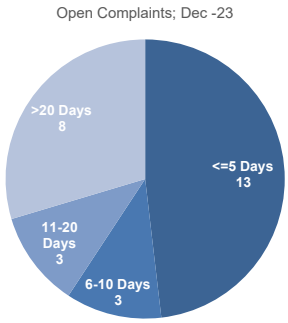
Stage 1

At least 80% of Stage 1 complaints will be completed within 20 working days by March 2024

Performance 43.9%

Local Performance





Performance by Service Area

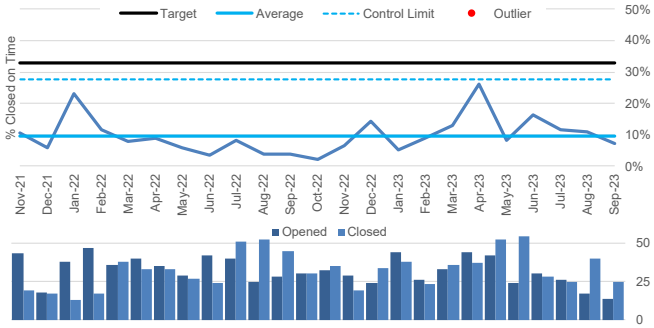
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Opened in Month	44	31	57	49	39	53	45	52	48	40	52	41
Due in Month	39	32	57	43	44	46	50	55	40	42	51	48
% Closed on time	46.2%	65.6%	57.9%	53.5%	56.8%	56.5%	60.0%	41.8%	57.5%	52.4%	72.5%	43.8%
Closed in Month	35	40	55	46	52	40	39	54	42	42	52	41
% Closed on time	62.9%	50.0%	63.6%	56.5%	40.4%	65.0%	71.8%	42.6%	54.8%	54.8%	75.0%	43.9%

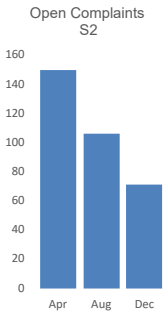
Stage 2

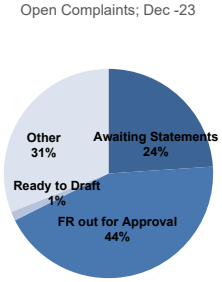
At least 33% of Stage 2 complaints are completed within 20 working days by March 2024

Performance 8.0%

Local Performance







Performance by Service Area

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Opened in Month	29	24	44	26	33	44	42	24	30	26	17	14
% Acknowledged on time	100.0%	95.8%	97.7%	96.2%	97.0%	93.2%	90.5%	100.0%	100.0%	92.3%	100.0%	100.0%
Due in Month	32	30	28	38	29	35	43	46	19	30	23	17
% Closed on time	6.3%	13.3%	14.3%	15.8%	6.9%	17.1%	16.3%	10.9%	15.8%	20.0%	26.1%	5.9%
Closed in Month	19	34	38	23	36	37	52	54	28	25	40	25

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Healthcare Associated Infection Report (HAIRT)**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Julia Cook, Infection Control Manager**

1 Purpose

Update for Infection Prevention and Control for February 2024 committee to provide assurance that all IP&C priorities are being and will be delivered.

This is presented for:

- Assurance

This report relates to a:

- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update for Infection Prevention and Control for February 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 Control Committee February 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 Surgical Site Infections, *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. Please see below for new LDP Standards.

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

- New LDP standards are to reduce incidence of healthcare associated CDI by 10% from 2019 to 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**

- New 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)**

- New 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 Q23 2023 (July- September), NHS Fife was below the national rate for healthcare associated infection (HCAI).
- Q4 2023 (October - December, n=21), has seen a rise in the number of SAB cases, from Q3 2023 (Jul-Sep, n=17). Awaiting national comparison.
- The total number of SABs (n=90) during 2023 (Jan-Dec) was lower than in 2022 (n=92)
- There have been no further dialysis line related SABs since the last report.
- NHS Fife had achieved over a full year without a PVC related SAB (prior to case in October) and over 525 days for CVC related SABs.

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 Q3 2023 (July- September), NHS Fife was below the national rate for HCAI.
- There was a significant reduction in the total number of CDI cases in Q4 (Oct-Dec 23, n=2), compared to Q3 (Jul-Sep, n=12). This improvement was also reflected in the number of HCAI cases during Q4 (n=2), compared to Q3 (n=4). Awaiting national comparison.
- The cumulative total of CDIs during 2023 (n=47) is higher than during 2022 (n=40) and 2021 (n=44).

Current CDI initiatives

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

ECB

- During Q3 2023 (July- September), NHS Fife was below the national rate for HCAI.
- There was a reduction in the number of ECBs (n=235) during 2023, when compared to the previous 2 years. This reduction is also reflected in the number of HCAI cases and CAUTI related ECBs.

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 (November - December 2023)

Norovirus

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

Seasonal Influenza

- There have been 2 new closures due to confirmed Influenza during this time period.

COVID-19

- 10 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 (September – end of October 2023)

Healthcare Improvement Scotland (HIS): Safe Delivery of Care Inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

- Full publication: Thursday 26th October.
- 2 Recommendations
- 9 Requirements
- 4 areas of Good Practice

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 3 (October - December 2023) was **96%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (October - December 2023) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 3 (October - December 2023) NHS Fife achieving **Green** status.

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 provision of a clean and safe working environment, and to overall staff health and wellbeing.

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 Diversity, including health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Control Committee February 2024

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Healthcare Associated Infection Report

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

Infection Prevention
and Control Team

Fife Health & Social Care Partnership

NHS Fife

HAIRT Report

HAIRT Report for Infection Control Committee on 7th February 2024

(Validated Data up to end of December 2023)

February 2024

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

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

During Q3 2023 (July- September), NHS Fife was below the national rate for healthcare associated infection (HCAI).

The total number of SABs (n=90) during 2023 (Jan-Dec) was lower than in 2022 (n=92)

There have been no further dialysis line related SABs since the last report.

NHS Fife had achieved over a full year without a PVC related SAB (prior to case in October) and over 525 days for CVC related SABs.

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

During Q3 2023 (July- September), NHS Fife was below national rate for HCAI.

There was a significant reduction in the total number of CDI cases in Q4 (Oct-Dec 23, n=2), compared to Q3 (Jul-Sep, n=12). This improvement was also reflected in the number of HCAI cases during Q4 (n=2), compared to Q3 (n=4). Awaiting national comparison.

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

During Q3 2023 (July- September), NHS Fife was below the national rate for HCAI.

There was a reduction in the number of ECBs (n=235) during 2023, when compared to the previous 2 years (2022, n=277 and 2021, n=249). This reduction is also reflected in the number of HCAI cases (2023, n=113, 2022, n=123 and 2021, n=127) and CAUTI related ECBs (2023, n=29, 2022, n=32 and 2021, n=35).

COVID-19

The weekly ARHAI Scotland nosocomial report has now ceased.

1.2 Challenges:

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.

SABs

Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs, ongoing improvement work continues.

Q4 2023 (Oct-Dec, n=21), has seen a rise in the number of SAB cases, from Q3 2023 (Jul-Sep, n=17). Awaiting national comparison.

There were 11 PWID related SABs during 2023. This is the same number as during 2022, but higher than in 2021, when there were 4 cases.

CDI

The cumulative total of CDIs during 2023 (n=47) is higher than during 2022 (n=40) and 2021 (n=44). This increase is also reflected in the number of HCAI (HAI+HCAI+Unknown) cases (2023, n=33, 2022, n=30 and 2021, n=28). IPCT will continue to monitor cases to assess if there is a sustained rise.

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

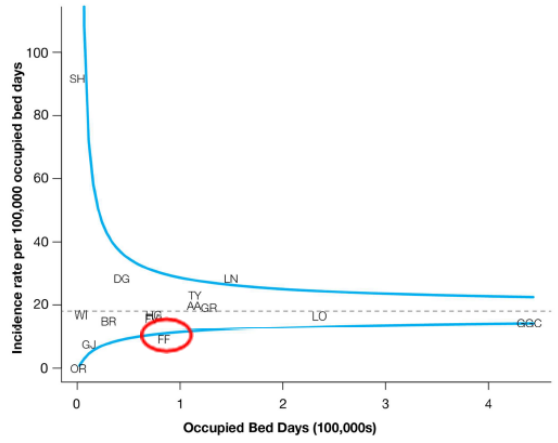
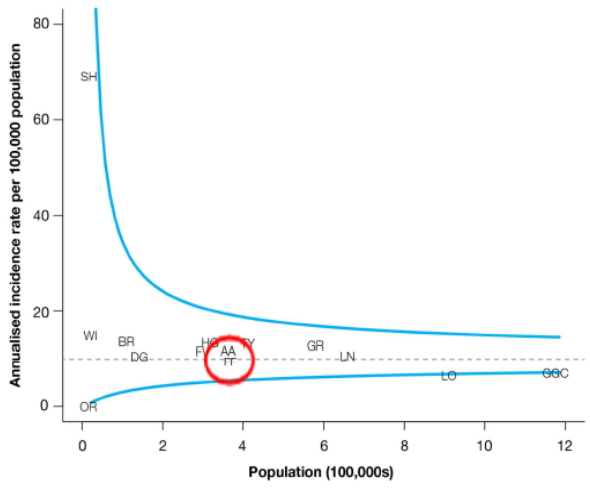
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) and enhanced surveillance reporting remains paused for the time being.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q4 2023 (Oct-Dec) **(Q4 2023 National comparison awaited)**				
In Q4 2023 NHS Fife had:	21 SABs	10 HCAI/HAI 11 CAI	This is **UP** from:	17 Cases in Q3 2023

Q3 2023 (Jul-Sep) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **9.2**	Per 100,000 bed days	CAI SABs rate: **9.5**	Per 100,000 Pop
No of HCAI SABs: 8		No of CAI SABs: 9	
This is **BELOW** National rate of 18.1		This is **BELOW** National rate of 10.1	
			
NHS Fife was not an outlier for SABs in Q3 2023.			

New standards for reducing all Healthcare Associated SAB by 10% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2024**
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 September 2023 (HPS)		
SAB by rate 100,000 Total bed days	**13.2** per 100,000 TBDs	
SAB by Number of HCAI cases	**47**	

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- Weekly reports issued to Senior Charge Nurses if their ward has failed to achieve **90%** of all PVC being removed prior to the 72hr breach.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There have been 8 dialysis line related SABs during 2023. Renal services carried out a CCR of each case (Jan-Apr 2023 cases) and the findings were discussed at a `Super SAER` meeting on 26th June 2023. The most recent case (August 2023) has been Datix`d by the Consultant Microbiologist.

As of **01/01/2024** the number of days since the last confirmed SAB is as follows:	
CVC SABs	525 Days
PWID (IVDU)	24 Days
Renal Services Dialysis Line SABs	133 Days
Acute services PVC (Peripheral venous cannula) SABs	75 Days

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

2.2 Current Risk Register Rating

Corporate Directorate – Nursing Directorate Infection Control Team Risk Register

ID: 637 SAB LDP Standard		
Initial Risk Level	**Current Risk Level**	Target Risk Level
Moderate 12	**Moderate Risk 9**	Low Risk 6

2.3 Current SAB Initiatives

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

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

2.4 National MRSA & CPE screening programme

MRSA

An uptake of 90% with application of the MRSA Clinical Risk Assessment (CRA) screening is necessary in order to ensure that the national policy for MRSA screening is effective

NHS Fife achieved **100%** compliance with the **MRSA** CRA in Q4 2023 (Oct-Dec)

This was **ABOVE** Q3 2023 (93%), and **ABOVE** the compliance target of 90%.

Awaiting national comparison for Q4 2023

MRSA Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	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
Fife	88%	93%	98%	98%	98%	100%	100%	98%	93%	100%
Scotland	81%	82%	81%	80%	78%	74%	78%	81%	80%	N/K

CPE (Carbapenemase Producing Enterobacteriaceae)

From April 2018, CRA has also included screening for CPE.

NHS Fife achieved **100%** compliance with the **CPE** CRA for Q4 2023 (Oct-Dec)

This was **EQUAL** to the compliance rate in Q3 2023

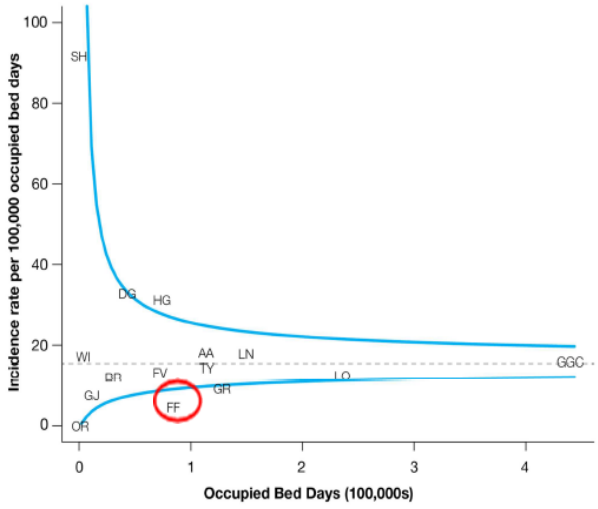
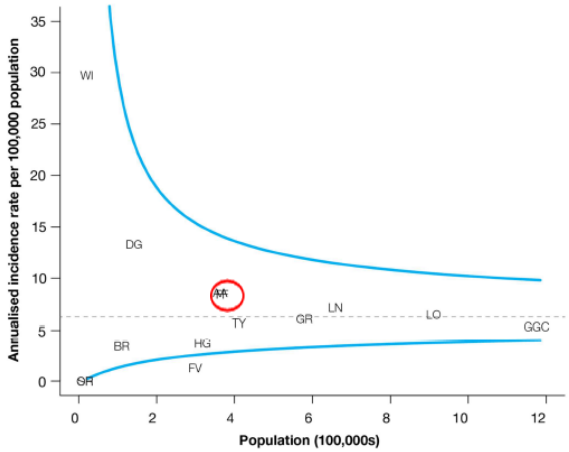
Awaiting national comparison for Q4 2023

CPE Critical risk assessment (CRA) screening KPI compliance summary:

Quarter	Q3 2021 Jul-Sep	Q4 2021 Oct-Dec	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
Fife	100%	98%	100%	98%	100%	100%	100%	100%	100%	100%
Scotland	82%	80%	80%	79%	78%	76%	77%	80%	81%	N/K

3 Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dec 2023 **(Q4 2023 HPS National comparison awaited)**				
In Q4 2023 NHS Fife had:	2 CDIs	2 HCAI/HAI/Unknown 0 CAI	This is **DOWN** from	12 Cases in Q3 2023
Q3 (Jul-Sep) 2023 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: **4.6**	Per 100,000 bed days	CAI CDIs rate: **8.5**	Per 100,000 Pop	
No of HCAI CDIs: 4		No of CAI CDIs: 8		
This is **BELOW** National rate of 15.5		This is **ABOVE** National rate of 6.2		
				
NHS Fife was not an outlier for CDIs in Q3 2023.				

New standards for reducing all Healthcare Associated CDI by 10% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
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**
Current 12 Monthly HCAI CDI rates for Year ending September 2023 (HPS)		
CDI by rate 100,000 Total bed days	**10.9** per 100,000 TBDs	
CDI by Number of HCAI cases	**39**	

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 9**	Low Risk 6

3.3 Current CDI initiatives

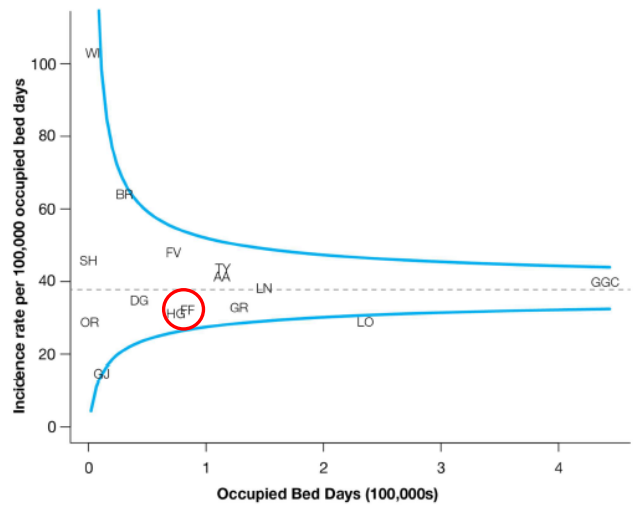
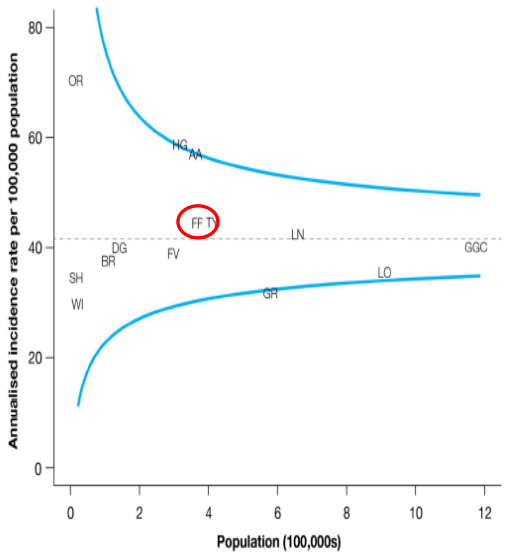
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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: Q4 (Oct-Dec) 2023 **(Q4 2023 HPS National comparison awaited)**				
In Q4 2023 NHS Fife had:	69 ECBs	34 HAI/HCAIs 35 CAIs	This is **UP** from	68 Cases in Q3 2023
Q4 2023 There were **11** Urinary catheter associated (1 of which was from a Suprapubic catheter) ECBs, which was higher than during Q3 2023, when there were 9 CAUTIs.				

Q3 (Jul-Sep) 2023			
HPS Validated data ECBs with HPS commentary *Please note for HPS reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **32.2**	Per 100,000 bed days	CAI ECBs rate: **44.5**	Per 100,000 Pop
No of HCAI ECBs: 28		No of CAI ECBs: 42	
This is **BELOW** National rate of 37.8		This is **ABOVE** National rate of 41.6	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

Two HCAI reduction standards have been set for ECBs:

New standards for reducing all Healthcare Associated ECBs by 25% by 2022 (from 2018/2019 baseline). This standard was extended to 2023 and will be extended for a further year to 2024		
New standards for reducing all Healthcare Associated ECB by 25% by 2024 (from 2018/2019 baseline).		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB 25% reduction target by 2024**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending September 2023 (HPS)		
ECB by rate 100,000 Total bed days	**30.0** per 100,000 TBDs	
ECB by Number of HCAI cases	**107**	

2021-2017 NHS Fife's Urinary catheter Associated ECBs –

HPS data Q1 2023 data still awaited

Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals)
CATHETER Device related *E.coli* Bacteraemia
Count of Device- Catheter over Total Fife **HAI** ECBs

	NHS Scotland	**NHS Fife**	Rate calculation
2023 Q4	TBC	***35.7%**	
2023 Q3	TBC	***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 HPS when Q3 & Q4 2023 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
2023 Q4	TBC	***30.0%**	
2023 Q3	TBC	***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 HPS when Q3 2023 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 IPC Surveillance team continue to liaise with the UCIG last held on 10th November 2023. 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 2023, there were 29 CAUTI ECBs (25 from urinary & 4 from a supra-pubic catheter). 9 of these have been associated with trauma.

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

CAUTI insertion & maintenance bundles have now been installed onto Patientrack in February 2022 and were trailed on V54 ward. Amendments to the tool are now awaited by Patientrack before this can then be rolled out across the board.
A new group has been formed, chaired by Dr Morris, to push forward the ecatheter bundles onto Patientrack. This 1st met on 21.12.23 & plans to meet again on 26.1.24 to work with D&I to install.

5. Hand Hygiene

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

5.1 Trends

- Unable to report
- ICM raising with Senior Management and D&I Teams

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 3 (Oct-Dec 2023) was **96.0%**.
- The cleaning compliance score for NHS Fife & each acute hospital can be found in Section 11

6.1 Trends

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

- **National Cleaning Services Specification**

Domestic Location	Q3 Oct-Dec 23	Q2 Jul-Sep 23
Fife	96.0%↑	95.6%
Scotland	TBC	95.2%

- The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (Oct-Dec) 23 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 23	Q2 Jul-Sep 23
Fife	95.9%↓	96.0%
Scotland	TBC	96.0%

- The Estates Monitoring – quarterly compliance report result for Quarter 3 (Oct-Dec) 23 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

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

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.

November – end of December 2023

Norovirus
Main points
• The provisional total of laboratory reports for norovirus in Scotland up to the end of week 01 of 2024 (week ending 07 January 2024) is 78.
• In comparison, to the end of week 01 in 2023 PHS received 54 laboratory reports of norovirus. The five-year average for the same time period between years 2015 and 2019 was 33.

There have been 4 ward closures due to Norovirus or suspected outbreak since last ICC report

Seasonal Influenza

Main points Overall Assessment 1 January to 7 January (ISO week 1):

- Measures of respiratory symptoms in the community via calls to NHS24 and attendances at GP consultations (GP ILI) show **Low** activity levels during the reporting period.
- Virology data showed influenza remained at **High** activity level in week1. With **Moderate** or **High** activity levels were observed among most age groups.
- RSV decreased from Moderate to **Low** activity level
- Mycoplasma pneumoniae was at **High** activity level.

- Emergency hospital admissions because of influenza decreased from 452 to 350, for RSV from 188 to 29, and for COVID-19, from 381 to 350.
- ICU/HDU admissions decreased for influenza and remained low for RSV and COVID-19.

There has been 2 closures due to confirmed Influenza since the last reporting period.

COVID-19

November – December 2023, there has been 10 new COVID-19 outbreaks/incidents reportable to ARHAI Scotland during this reporting period.

3_Hospital	5_Ward	Date of reporting	Total no. deaths	Total no. patients	Total no. staff
QMH	WARD 1	08/12/2023	0	8	5
QMH	WARD 8	13/11/2023	0	3	0
SACH	WARD 2	08/12/2023	0	2	1
SACH	WARD 1	13/11/2023	0	4	1
GLENROTHES	WARD 1	21/12/2023	0	3	3
GLENROTHES	WARD 2	21/12/2023	0	7	6
STRATHEDEN	Dunino	01/11/2023	0	5	6
WMBH	Ravenscraig	22/12/2023	0	3	1
CAMERON	Balcurvie	21/12/2023	1	11	3
CAMERON	Balgonie	06/12/2023	0	5	2

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 advises surgical site infection (SSI) and enhanced 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 (November – end of December 2023)

Healthcare Improvement Scotland (HIS): Safe Delivery of Care Inspection - Unannounced inspection to Victoria Hospital, NHS Fife, 31st of July- 2nd of August.

- Full publication: Thursday 26th October.
- 2 Recommendations
- 9 Requirements
- 4 areas of Good Practice

10. Assessment

- **CDIs**: The number of *Clostridioides difficile* cases has increased in 2023. This is rise is also reflected in the number of HCAI cases. Continuous monitoring will highlight if this is an ongoing problem, which requires addressing.
- Reducing incidence of recurrence of infections is key to reducing healthcare CDIs
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce peripheral vascular device infections have been effective but remains a challenge, with local surveillance continuing
- Ongoing monitoring of dialysis line related SABs. IPCT will support Renal service in investigating cases and any subsequent improvement strategies.
- IPCT will continue to support the Addictions Service in addressing the reduction of SABs in PWIDs
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge

- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- **SSIs surveillance** currently suspended during COVID pandemic for C-sections, Large bowel surgery and Orthopaedic procedure surgeries (Total hip replacements, Knee replacements & Repair fractured neck of femurs). Awaiting further instruction regarding resumption of surveillance. Increased resources and months of preparing will be required prior to recommencing.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT template provides CDI, SAB & ECBs information for NHS Fife categorizing by:

- Total NHS Fife
- VHK wards,
- QMH wards (wards 5,6,& 7) &
- Community Hospital wards (QMH 1-4, SH, SACH, GH, LH, CH, AH, RWH, WBH, All Hospices)
- Out of Hospital (Infections that occur in the community/GP or within 48 hours of hospital admission

ECBs, CDIs & SABs are 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-23	4	3	7	6	1	7	9	5	14
May-23	5	4	9	5	0	5	12	9	21
Jun-23	4	6	10	5	1	6	5	9	14
Jul-23	3	4	7	1	2	3	12	15	27
Aug-23	4	1	5	1	1	2	11	18	29
Sep-23	1	4	5	2	5	7	5	7	12
Oct-23	4	4	8	1	0	1	14	13	27
Nov-23	4	2	6	0	0	0	11	13	24
Dec-23	2	5	7	1	0	1	9	9	18
Jan-24	0	0	0	0	0	0	0	0	0
Feb-24	0	0	0	0	0	0	0	0	0
Mar-24	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%) TOTAL FIFE												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	96.0	96.4	95.9	95.9	95.9	95.9	95.6	95.6	95.7	96.0	96.2	95.8

Estates Monitoring Compliance (%) TOTAL FIFE												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	96.6	96.3	96.3	96.5	96.5	96.0	96.1	95.7	96.2	95.7	96.2	95.9

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	4	4	2
May-23	2	3	3
Jun-23	1	3	1
Jul-23	1	0	2
Aug-23	3	0	6
Sep-23	1	0	3
Oct-23	3	1	7
Nov-23	4	0	2
Dec-23	0	0	3

Cleaning Compliance (%) Victoria Hospital												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	95.9	96.6	95.8	96.1	95.6	96.1	95.4	95.4	95.8	96.4	96.0	95.9

Estates Monitoring Compliance (%) Victoria Hospital												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	97.1	96.5	97.5	97.5	97.3	97.0	97.3	96.2	97.6	97.1	97.3	96.5

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	0	1	1
May-23	1	1	0
Jun-23	0	0	0
Jul-23	0	0	0
Aug-23	1	0	0
Sep-23	0	0	0
Oct-23	0	0	1
Nov-23	0	0	1
Dec-23	1	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	96.9	96.5	95.9	96.5	96.7	96.6	95.8	96.6	96.4	96.8	97.4	96.6

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Overall	96.1	95.5	94.8	94.9	95.5	94.1	94.6	95.0	94.4	95.5	95.3	96.4

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-23	0	1	1
May-23	0	0	0
Jun-23	0	0	0
Jul-23	0	0	0
Aug-23	0	0	0
Sep-23	0	0	0
Oct-23	0	0	0
Nov-23	0	0	0
Dec-23	0	0	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-23	0	3	0	1	5	5
May-23	2	4	1	0	9	9
Jun-23	3	6	2	1	4	9
Jul-23	2	4	1	2	10	15
Aug-23	0	1	1	1	5	18
Sep-23	0	4	2	5	2	7
Oct-23	1	4	0	0	6	13
Nov-23	0	2	0	0	8	13
Dec-23	1	5	1	0	6	9

Appendix 1 References and Links

References & Links
Understanding the Report Cards – Infection Case Numbers *Clostridioides difficile infections (CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month by Healthcare Associated (HCAI & HAI) & Community (Community/Unknown) onset. More information on these organisms can be found on the NHS24 website: *Clostridioides difficile*: https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/ *Staphylococcus aureus* : https://www.hps.scot.nhs.uk/a-to-z-of-topics/staphylococcus-aureus-bacteraemia-surveillance/ For each hospital, the total number of cases for each month are those, which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card. **Targets** There are national targets associated with reductions in C.diff and SABs and from 2019 for e.coli bacteraemias (ECBs). More information on these can be found on the Scotland Performs website: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance **Understanding the Report Cards – Hand Hygiene Compliance** Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used. **Understanding the Report Cards – Cleaning Compliance** Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/ **Understanding the Report Cards – *'Out of Hospital Infections'*** *Clostridium difficile infections* and *Staphylococcus aureus bacteraemia* cases can be associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infections from community sources. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to NHS Fife which are not attributable to a hospital.
For HPS categories for Healthcare Associated Infections: **https://www.hps.scot.nhs.uk/web-resources-container/quarterly-epidemiological-commentary-for-the-surveillance-of-healthcare-associated-infections-in-scotland-methods-caveats/**

Appendix 2 Categories of Healthcare & Community Infections

Categories of Healthcare & community Infections

		Quarterly Epidemiology Commentary category	
		Healthcare associated infection case	Community associated infection case
CDI[1] Enhanced ECB[2] Enhanced SAB[3] surveillance category	Hospital acquired infection (HAI)	X	
	Healthcare associated infection (HCAI)	X	
	Community infection (CA)		X
	ECB/SAB not known		X
	CDI unknown	X[1]	

HPS **ECB** & **SAB** definitions for Hospital Acquired, Healthcare Associated, Community or Not known

Hospital Acquired Infection (HAI):
Positive Blood culture obtained from patient who has been
-Hospitalised for >48 hours
If the patient was transferred from another hospital the duration of the in-patient stay is calculated from the date of the first hospital admission
OR
-The patient was discharged from hospital in the 48 hours prior to the positive blood culture being obtained
OR
-A patient receives regular haemodialysis as an outpatient

Community Infection
-Positive Blood culture obtained from a patient with 48 hours of admission to hospital who does not fulfil any of the criteria for the healthcare associated blood stream infections

Not known:
-Only to be used if the ECB is not a HAI and unable to determine if community or HCAI

Healthcare Associated Infection (HCAI):-
Positive blood culture obtained within 48 hours of admission to hospital and fulfils one or more of the following criteria:
-Was hospitalised overnight in the 30 days prior to the +ve blood culture being obtained.
OR
-Resides in a Nursing home, long term facility or residential home
OR
-IV,IM, Intra-articular or sub cut medication in the 30 days prior to the positive blood culture,
but EXCLUDING IV illicit drug use.
OR
-Underwent venepuncture in the 30 days before +ve BC
OR
-Underwent medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days before +ve BC
OR
-Underwent any care for chronic medical condition or manipulation of medical device by a healthcare worker in the community in the 30 days prior to the +ve BC being obtained i.e. podiatry or dressing of chronic ulcers, catheter change or insertion
OR
-Has a long term indwelling device (i.e. catheter, central line, drain (excluding a haemodialysis line)

HPS **CDI** Definition for Hospital Acquired, Healthcare Associated, Unknown or Community onset	
HPS Linkage Origin Definitions	
CDI Origin	**Origin sub category : definitions**
Healthcare	**HAI :** Specimen taken after more than 2 days in hospital (day three or later following admission on day one)
	HCAI : Specimen taken within 2 or less days in hospital and a discharge from hospital 4 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital within 4 weeks of the specimen date **Unknown** : Specimen taken 2 or less days in hospital and a previous discharge from hospital 4-12 weeks prior to specimen date; or specimen taken in the community and a discharge from hospital in 4-12 weeks prior to the specimen date
Community	**CAI :** Specimen taken 2 or less days in hospital and no hospital discharges in the 12 weeks prior to specimen date; or not in hospital when specimen taken and no hospital discharges in the 12 weeks prior to specimen date.

CDI Surveillance Protocol link: https://www.hps.scot.nhs.uk/web-resources-container/protocol-for-the-scottish-surveillance-programme-for-clostridium-difficile-infection-user-manual/

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

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Alignment of NHS Fife Realistic Medicines / Value Based Health and Care Delivery Plan and the Scottish Government Value Based Health and Care Action Plan**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Emma O'Keefe, Linda McGourty, Kingsley Oturu**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy / directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Scottish Government has published the Value Based Health and Care Action Plan. This SBAR report is to assure the Clinical Governance Committee that the NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan aligns with the commitments and actions of the Scottish Government Value Based Health and Care Action Plan.

2.2 Background

The NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan was updated following a workshop in September 2023 to ensure Realistic Medicine/Value Based Health and Care principles are embedded in practice. It is by practising Realistic Medicine that we can achieve Value Based Health and Care. The Realistic Medicine/Value Based Health and Care Annual Delivery Plan RAG status is updated monthly, the narrative is updated quarterly

and reviewed annually. Reports are also sent to the National Realistic Medicine Policy Team in Scottish Government.

2.3 Assessment

The commitments and actions outlined in the National Valued Based Health and Care Action Plan informs the ambitions of the NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan.

The strategic aim of the National Value Based Health and Care Action Plan is:

"By 2030 all health and care professionals will be supported to deliver Value Based Health & Care. This will achieve the outcomes that matter to people and a more sustainable system."

The NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan takes cognisance of value-based health and care, ensuring that patient choice is respected and shared decision making practised in Fife.

These are underpinned by the principles of Realistic Medicine:

- Person Centred.
- Shared Decision making.
- Manage Risks better.
- Reduce harm and waste.
- Tackle unwarranted variation of care.
- Become Improvers and Innovators.

The NHS Fife Value Based Health and Care Delivery Plan does not stand alone and compliments and links to wider strategies and operates within broader health aims. The principles of Realistic Medicine are embedded in the NHS Fife's Population Health and Wellbeing Strategy (2023-2028) and the NHS Fife Cancer Framework. Six commitments are identified in the National Value Based Health and Care Action Plan and address both cross cutting and Realistic Medicine/Value Based Health and Care priorities as presented without hierarchy in Figure 1 below.

The Scottish Government will have oversight of overall strategic progress and direction of the National Value Based Health and Care Action Plan. The Scottish Government Realistic Medicine/Value Based Health and Care Team gives the NHS Fife Realistic Medicine/Value Based Health and Care Team the responsibility to review progress against 6 priorities (Figure 1).

Figure 1. National Strategy Commitments

The aims of the 2024-2025 Delivery plan are to ensure:

Systems: To align systems and policies to support Realistic Medicine/Value Based Health and Care.

Workforce: To equip health and social care staff with the knowledge and skills to embed Realistic Medicine/Value Based Health and Care in practice.

People: To empower and support people to engage with health and social care staff in shared decision making. People will be at the heart of the strategy.

2.3.1 Quality, Patient and Value-Based Health & Care

As above, the subject matter of his paper.

2.3.2 Workforce

Education and training of the workforce is required with regards to communication, shared decision making and person-centred care. Staff should also be encouraged to undertake training on TURAS on shared decision making. The principles of Realistic Medicine should be embedded in everything we do and not seen as an adjunct.

2.3.3 Financial

There is no specific reference to expected financial investment in the strategy itself however there are resource commitments detailed in the 2024-2025 Delivery plan.

- Ensure better use of Health and Care Resources by identifying unwarranted variation and low value interventions.
- Annual funding from Scottish Government is dependent on outcomes.
- For 2024/25, the Scottish Government has offered £30,000 to fund a Realistic Medicine Clinical Lead post for 1 day a week, and £30,000 to fund a Realistic Medicine Programme Manager for 3 days a week (Band 7).

  The funding element for the Clinical Lead covers the cost (current cost £28,775), however, it does not cover the Programme Manager cost for 3 days a week as this has not been uplifted in line with the agenda for change pay offer in recent years. Therefore, the funding provided is adequate to cover only 2 days per week (current cost £28,265) for a band 7 rather than the strategic recommendation of 3 days per week (current cost £42,398). This puts a strain on an already stretched resources if NHS Fife were to fund the additional day of a band 7 per week.
- Building time for workforce to do the recommended CPD.
- There is a cost in relation to the Question That Matter (QTM) information that are printed and sent with outpatient appointments.
- There may be costs associated with communications.
- The investment in embedding Realistic Medicine/Value Based Health and Care in NHS Fife, will save money in the long term (having good conversation and care that delivers most value for the person and clinical benefits outweigh the costs to the individual or the system).

2.3.4 Risk Assessment / Management

High quality evidence can increase our understanding of what works, maximise the chance of achieving the strategy's ambitions, and reduce delivery risk. NHS Fife has developed a local risk framework from workshops which identifies and mitigates potential risks to delivery of the Realistic Medicine/Value Based Health and Care in relation to:

- Engaging patients in 'risk v benefits' conversations/shared decision making.
- Empowering staff to feel confident in not doing low value investigations/treatment options.
- Raising awareness on harms and consequent complaints.
- Encourage sharing of learning around clinical decisions.
- Multidisciplinary Teams taking responsibility of risks rather than individuals.
- Continued funding risks.

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

Systems will be aligned to ensure equitable access to high quality services that deliver valuable outcomes that matter to all people thereby reducing health inequalities and improving population health.

2.3.6 Climate Emergency & Sustainability Impact

The strategy is aligned to the NHS Scotland Climate Emergency & Sustainability Strategy. The Realistic Medicine/Value Based and Health Care Delivery Plan aims to reduce waste/harm and manage risks better. It also links well with the Centre for Sustainable Delivery.

2.3.7 Communication, involvement, engagement and consultation

This paper has been informed by the Realistic Medicine Governance Workshop and circulated for comments to:

- Associate Director for Risk and Professional Standards
- Quality and Clinical Governance Senior Management Team
- Senior Leadership

2.3.8 Route to the Meeting

Executive Directors' Group – 15th February 2024

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, National Value Based Health and Care Strategy (2022) – can be accessed at this link: Delivering Value Based Health & Care: A Vision For Scotland (www.gov.scot)

- Appendix No 2, National Value Based Health and Care Action Plan (2023) – can be accessed at this link: Value Based Health and Care Action Plan (www.gov.scot)

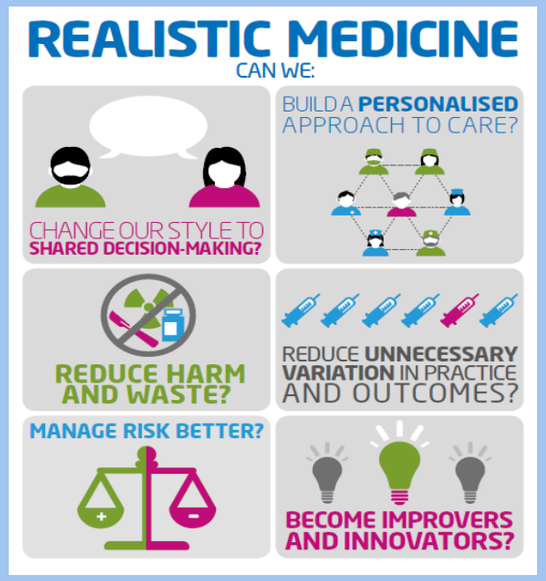
- Appendix No 3, NHS Fife Realistic Medicine/Value Based Health and Care Report (Flash Report)

- Appendix No 4, NHS Fife Realistic Medicine/Value Based Health Care Delivery Plan

Report Contact
NHS Fife Realistic Medicine Team
Email fife.qtm@nhs.scot

NHS Fife

Workshop Report 20th September 2023



Find out more on local Stafflink site here and National site here
or email fife.qtm@nhs.scot

Overview:

Scotland's vision is that by 2025, we will support the Health and Social Care workforce to practice Realistic Medicine, thereby enabling the delivery of high-quality, personalised care to the people of Scotland. To improve our understanding of the unique context of Fife and empower staff to practice Realistic Medicine (RM) and Value Based Health Care (VBHC), the RM Governance workshop was organised. The workshop was held in the Main Hall at Lyne bank Hospital Fife, on Wednesday 20th September 2023 to explore how RM and VBHC can be embedded in Fife. NHS Fife Chief Executive (Carol Potter) was at the meeting.

Workshop Aims:

The workshop sought to:

- Establish governance arrangements for embedding RM in the organisation
- To ensure the value of different Realistic Medicine projects is shared
- Identify ways to encourage staff to use the principles of Realistic Medicine in their practice overtly.

Who Attended:

The event was chaired by Dr Chris McKenna, Medical Director and Dr Shirley-Anne Savage, Associate Director of Quality and Clinical Governance and was attended by over 55 members of multi-disciplinary strategic teams from across NHS Fife and Fife Health and Social Care Partnership.

Who Presented:

- Dr Chris McKenna, Medical Director, NHS Fife gave an overview of Realistic Medicine, progress and the challenges across NHS Fife.
- Dr Catherine Labinjoh from Scottish Government presented on Realistic Medicine and Value Based Health and Care.
- Margo McGurk, Director of Finance & Strategy, NHS Fife provided insight on 'outcomes that matter and managing resources wisely'.
- Dr Rishma Maini and Dr Philip Korsah from Public Health Scotland and Centre for Sustainable Delivery team respectively presented on 'unwarranted variation of care'.
- Emma O'Keefe, (RM Clinical Co-Lead), gave an overview of the World Café workshop and participants were divided into groups to answer the workshop questions. Dr Linda McGourty (RM Clinical Co-Lead) also provided support with other facilitators (including Dr Kim Steel (Associate Director of Medical Education), Kirsty MacGregor (Associate Director of Comms) and Senior Managers of the NHS Fife Clinical Governance Team).

"adopting a paediatric mindset": Paediatricians appreciate the "cost" to doing investigations. Blood, urine or CSF sampling in children/babies is not always easy to do or they hurt and so they think very carefully about whether or not they are required. Similarly with radiological investigations there is a reluctance to do CT scans with the young more vulnerable to the effects of irradiation and with other imaging the patients may not stay still and so require sedation or anaesthetic.'' John Morrice (NHS Fife, Associate Medical Director for Women and Children)









'It is by practising realistic medicine that we are able to achieve value-based health and care'

Breakout Session Findings: Themes

1. How do we encourage local teams to engage with the atlas of variation to add value?

- Knowledge and skills to interpret and use the Atlas of Variation
- Engagement and buy-in with strong leadership
- Access to local data for improvement
- Engagement of staff to use Atlas of Variation data for improvement

2. How can we use resources wisely?

- Prevention/public health to make every opportunity count and reduce low value interventions
- Realistic prescribing.
- Use of digital innovation strategies
- Communication and managing expectations

3. How do we embed RM in education/training?

- Top 5 Personal Development Plans (PDP) modules
- Induction of new staff/cultural modelling
- Patient, School(early life, higher, medical), Interprofessional and public health education.
- Outcome measures/data awareness

4. How do we communicate RM principles effectively?

- Communicate with consistent, simple language (patient letters/Anticipatory Care Plans/Annual Delivery Plans) and practice RM/VBHC across patient journey
- Consider VBHC in everything we do, including complaints
- Prioritise patient/staff stories
- Education and time for staff to practise shared decision making
- Engagement with health and social care
- Role of Scottish Government in campaigns
- Good conversations/EC4H (Effective Communication for Health care

5. How do we manage risks better in delivering VBHC?

- Engage patients in 'risk v benefits' conversations/shared decision making
- Empower staff to feel confident in not doing low value investigations/treatment options
- Raising awareness on harms and consequent complaints
- Encourage sharing of learning around clinical decisions
- Teams taking responsibility of risks rather than individuals (MDTs)

6. How do we embed RM in everything we do?

- Using BRAN (Benefits, Risks, Alternatives, do Nothing) questions at all stages of the patient journey
- Focus on outcomes for people(Quality Improvement/Qualitative measures)
- Embed RM principles in all NHS Fife strategies, frameworks, SBARS (Situation, Background, Assessment, Recommendations), SOPS (Standard Operating Procedures), Business Plans and other documents
- Adequate resource allocation

7. How do we embed RM in governance structures?

- Managed Clinical Networks (pledges, badges, 'one little thing')
- Clinical Governance Committee
- Sustainability/Pathways (patient-initiated reviews)
- DATIX/patient-based complaints
- National Care Service/St Andrews University/SCOTGEM

Themes linked with analysis framework in RM action plan below

Breakout Session Analysis : Systems, staff and patients

1. Systems

To align systems and policies to support Realistic Medicine/Value Based Health and Care

2. Staff/Health Care Workers

To equip health and social care staff with the knowledge and skills to embed Realistic Medicine/Value Based Health and Care in practice

3. People

To empower and support people to engage with health and social care staff in shared decision making

What Participants said about the Workshop?

- *"Really good to see the interlinking between the different areas of my role and how having a focus on realistic medicine is helpful in all of that."*
- *"This was an excellent workshop and great to see the energy in the room. Look forward to being part of this in the future."*
- *"Fantastic engaging workshop"*
- *"Workshops were thought provoking and all interlinked. Need permission to be brave and try different approaches If doing things differently potentially could cost more initially but with longer term gains"*

Next Steps

- We will actively engage with all clinical staff across NHS Fife and patients in developing a communications framework through workshops.
- Ensure that RM principles are embedded in NHS Fife documents (guidelines, SOPs, SBARs etc).
- Work with NHS Fife stakeholders to embed actions from themes into RM action plan and implement them.

Contact NHS Fife RM team if you have any questions: fife.qtm@nhs.scot

Realistic Medicine/Value Based Health and Care Delivery Plan 2024-2025

- The principles and intentions set out in the Realistic Medicine/Value Based Health and Care Delivery Plan will be fully realised through the support of a local annual delivery plan.
- The Realistic Medicine (RM) Delivery Plan for 2024-2025 is set out below:

Systems, Staff and Public Strategic Framework

1. **Systems**
   To align systems and policies to support Realistic Medicine/Value Based Health and Care

2. **Staff/Health Care Workers**
   To equip health and social care staff with the knowledge and skills to embed Realistic Medicine/Value Based Health and Care in practice

3. **People**
   To empower and support people to engage with health and social care staff in shared decision making

strategy		Workstream	Description/ Objectives	Lead(s)	Timescale	RAG	Update/Status
People	1.1	Work with NHS Fife Patient Experience Teams to engage with patients and embed RM principles.	Continue to work with the Patient Experience Teams	RM Leads/Senior Project Manager/Head of Patient Experience	Mar 25		Engagement made with Patient Experience team and with the communications team to scope a comms plan, along with developing a public facing web page, public survey and review of information currently hosted on staff intranet (Staff Link) in relation to Realistic Medicine. Fortnightly Teams meetings have been fixed to check on progress with the comms plan, survey, and staff link review, ready to start any activity from 1st April 2024. The Organisational Learning Group (OLG) was supported in developing process maps for more efficient and effective process of engaging with patients/General Practitioners (GPs) with letters. The Patient Experience Report now incorporates Realistic Medicine We are also collaborating with Health Literacy (NHS Fife Health Promotion) in embedding Realistic Medicine in their programs.
	1.2	Patients And Families Encouraged to Ask Benefits Risks, Alternatives, Do Nothing (BRAN)/ Questions That	Engage with patients in primary care to ask QTM. Engage with patients in secondary care and empowering them to	RM Leads/Senior Project Manager/Acute Services/Health care Workers/Medical Records/Digital and Information	Mar 25		QTM developed on QR code. QTM continues to be shared out with appointment letters.

		Matter (QTM) questions.	ask BRAN/QTM questions. Continue to roll out QTM on posters, leaflets and QR codes digitally.				
	1.3	Engagement with Strategic Partners to embed Realistic Medicine	Engage with educational systems (high school, medical schools to embed Realistic Medicine) Engage with health and social care partnerships	RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Aug 24		Engagement being made with contact from health and social care partnership. Meeting with Director of Acute Services and Director of Fife Health and Social Care Partnership
	1.4	Collaborations for communications (more details in communications plan)	Work together with Scottish Govt on Media Campaigns Mainstream person-centred stories into comms. Consistent Comms (e.g., outpatient waiting rooms TV/banners)	RM Leads/Senior Project Manager Comms and Medical Director	Mar 25		Engagement with Scottish government being undertaken. Advent calendar for realistic medicine was carried out during Easter 2023. Re-run staff enlightenment campaign on desktop

Workforce	2.1	Engage with Executives and Non-Executives Directors/work force committees, medical, nursing and AHP staff to ensure RM course is recommended on TURAS for staff/receptionists	Meetings and workshops being held with Directors to recommend RM course on TURAS and Effective Communication for Healthcare (EC4H).	RM Leads/Senior Project Manager Clinical Leads for Acute, HSCP, nursing and AHPs with promotion from Comms	Mar 25		Engagement with Directors started with the Governance Workshop held in Sept 2023 As a follow on, the Medical Director organised a Board development session for Executive Directors and Non-Executive Directors in Oct 2023.
	2.2	Encouraging Staff to access RM Module on TURAS (Priority)	Staff encouraged to access RM module through survey and link to course. Acquire access to TURAS data to monitor training	Clinical Leads for Acute, HSCP and AHPs/Workforce	Aug 24		Survey currently under development.
	2.3	Develop Communication Plan/Generic Power Point Presentation and engage with dedicated Comms Person	Develop comms plan. Develop Generic Power Point presentation. Link up with dedicated Comms Person	RM Leads/Senior Project Manager/ Communications team	Jun 24		Comms plan and power point presentation complete. Dedicated communications person identified, and engagement commenced.
	2.4	Develop Programme Management Workshops (Risk/Benefits/ Governance)	Deliver workshops to streamline message (what is RM, Shared Decision Making (SDM), Values based?)	RM Leads/Senior Project Manager	Jun 24		Risks, Benefits, and Governance workshops undertaken.

	2.5	Engagement with pharmaceutical staff on realistic prescribing	Engaging with pharmaceutical staff to embed realistic prescribing in practice. Re-establish Realistic Prescribing Group	NHS Fife Pharmaceutical staff	Dec 25		Realistic prescribing guidelines for hypertension, diabetes management and frailty developed.
	2.6	Engagement with Health Care workers to embed RM in practice	Disseminate message in grand round. Engage with GP clusters. Attend Rapid Cancer Diagnostic Service (RCDS) Meeting, engage with practice nurses and with nurses in training. Engage with Undergraduate (UG)/Postgraduate (PG) Doctors in training. Scottish Graduate Entry Medicine (SCOTGEM) Engage with General Medical Council (GMC)	Medical Education/Public Health Department	Mar 25		Engagement with PG doctors in training, GMC and RCDS and Practice Nurses complete. Plans underway to meet with GP clusters and Area Committee.

	2.7	Systems leadership Engagement	Transitional change Culture of stewardship Make Every Opportunity Count- use teaching moments- motivational interviewing	Director of Acute Services and CL/Managers Acute/Primary Care/Social Care/Health Promotion	Dec 25		We are involved in meetings to with the NHS Fife, Health and Social Care Partnership, prevention and early intervention strategy,
Systems Alignment	3.1	Establish RM Programme Governance arrangements	Development and review of Governance documents and SBARs	RM Leads/Senior Project Manager	Jun 24		Governance workshop has been undertaken and SBAR developed. Awaiting assurance that governance arrangements are in line with NHS Fife's vision.
	3.2	Establish RM Programme Management Office docs (risk register, issue register, plan)	Continue to embed new clinical and care governance structures/processes including services.	RM Leads/Senior Project Manager	Mar 25		Risk register complete. Issue register complete. RM Plan, Communications plan being updated.
	3.3	Embedding Of RM In TURAS (Priority)	Embed RM QTM into NHS Fife training/induction including, recommending TURAS from Induction Provide Easy link for staff to access RM TURAS course from staff intranet (Blink)	RM Leads/Senior Project Manager	Mar 25		SBAR written to Scottish Government and engagement with NES undertaken to suggest how RM models may flow better.

			Engage with NES to suggest, RM modules flow better on one page				
	3.4	Embed RM principles in NHS Fife Documents, systems, and processes (Standard Operating Procedures (SOPs), Situation, Background, Assessment, Recommendations (SBARs) etc)	Supporting training for staff including ensuring the RM is referred to in NHS Fife Documents	Clinical Leads for Realistic Medicine/Senior Project Manager	Jun 24		NHS Fife Documents (SBAR templates) revised to include sections referring to Realistic Medicine principles.

	3.5	Digital & Information engagement for increased functionalities to improve access to RM module/ information	Raise profile of RM by Digital & Information facilitating GP access Digital & Information for RM/SDM QR Codes Pop up on laptops Electronic Patient records RM embedded in NHS Fife webpage (Blink) QTM into Near Me (both pt and staff) FROG- Join up Digital & Information System- primary & secondary- ACPs and DNACPRs e.g., hospital review of medicines changes.	NHS Fife Digital & Innovation /Communications Teams (Communications Manager, Associate Director of Communications) Clinical Leads and Managers	Oct 25		Engagement with D&I Associate Director and programme manager. RM embedded in NHS Fife webpage (intranet) QR does developed for QTM. Pop up on laptops across NHS Fife undertaken. Consultations on how to embed in electronic patient records undertaken
	3.6	Ensure information on – Benefits, Risks, Alternatives, Do Nothing (BRAN), Questions that matter (QTM) on patient facing and staff facing sides of near me (video	Engage with Comms and Digital & Information teams for prompts on Digital & Information systems such as TRAK to ask BRAN/QTM Questions.	RM Leads/Senior Project Manager	Apr 25		Engage with Digital & Information teams to see how QTM can be embedded in near me consultations digitally (pop ups)

		consultations) (Priority)					
	3.7	Evaluation Of Shared Decision Making from Patients' Perspectives (Priority)	Infection Prevention and Control (IPC) control surveys Harness Data from Care Opinion Get feedback from patient stories. Ask staff to engage with patient to fill feedback forms. Build feedback through SCOTGEM training projects. Use of Collaborate tool	RM Leads/Senior Project Manager	Apr 25		SCOTGEM/Care opinion work around ENT Planning to follow up patient journey via SCOTGEM. Consider Survey/feedback form (where they planning to use the QTM, did they use them?)
	3.8	Support Local Teams to work with Centre for Sustainable Development (CFSD) to Roll out, Active Clinical Referral Triage (ACRT), Patient Initiated Reviews (PIR), Effective, high-Quality Interventions and Procedures	Engage with colleagues in Public Health Scotland (Public Health Consultant) to facilitate considerations of atlas of variation. Engage with local teams to facilitate RM sensitive patient pathways. Engage with local NHS Fife Staff to consider	Acute/Ass MD Primary Care Clinical Leads and Management	Apr 25		Talk on atlas of variation undertaken at RM Governance workshop with strategic health care staff and more meetings being planned. There was representation from public health Scotland and centre for sustainable delivery (CFSD). The team have met with officials from national CFSD. Meetings have been held with local staff (health service managers, senior project manager (planned care), portfolio manager. We have attended CFSD national/local heat map meeting and embedded principles of Realistic Medicine We attend the monthly Integrated Planned Care Programme Board meetings where Realistic Medicine is a

		(EQUIP) Pathways (Priority)	use of the atlas of variation. Workshop led by Public Health Scotland (PHS)/Fife and Specialty Delivery Group to increase knowledge and skills to inpret and use Atlas of Variation (AoV) and also other local data sources for service improvement (to include AHPs and al services not within the AoV. Atlas of Variation and Patient initiated pathways & Triage (Rapid triage pathway) NHS Fife move to writing letters to patients and Copy (cc) in Health Care Professional Responsible for Care (HCP) – out patients and pathways Letters to patients with HCP cc in				standing agenda item to embed Realistic Medicine in the pathways.

	3.9	Whole system buy-in including GMC, Medical and Dental Defence Unions to enable staff to buy into model and culture to develop.	Engage with GMC and other staff to embed systematically in culture and model of working	GMC/Regulatory bodies, Medical and Dental Defence Unions, CLO,	Dec 25		Meetings have been held with GMC representatives as well as training of junior doctors on shared decision making.
Programme Management	4.1	Organisational Governance	Draft Programme Board Terms of Reference (TOR)	RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Apr 25		Draft Programme Board members and Terms of reference being developed. SBARs and delivery plans developed for submission to clinical governance committee and EDG.
	4.2	Management Control	Programme Board Meetings Meetings with other Boards to embed Realistic Medicine in Practice	RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Apr 25		Programme Management and RM team members meeting being organised. Participation in NHS Fife Clinical Governance Senior Managers Team meeting Participation in Integrated Planned Care Programme Board meetings Participation in RM network meeting Participation in RM network Programme Managers meeting Participation in Prevention and Early Intervention Strategy Development Group

	4.3	Benefits Management		RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Apr 25		Benefits Workshop undertaken. Benefits workshop report/outputs shared out. Benefits map being developed. Benefits Realisation plan being developed
	4.4	Risk Management		RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Apr 25		Risk Workshop undertaken. Risk workshop report/outputs shared out Risk register developed. Risk register being embedded in datix
	4.5	Communications Management	Meetings with Communications team Implementation of communications and engagement plan Organisation of Communications program that enables better health care worker/patient communication/engagement	RM Leads/Senior Project Manager Associate Director for Risk and Professional Standards	Apr 25		Meeting with Communications and patient engagement teams undertaken. Communications and engagement plan developed and shared out. Survey for patient facing communications program being planned.

Action Status Key
Completed
Significant Progress
Started
Not started

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Safe Delivery of Care Inspection and Learning Review - Victoria Hospital from 31 July 2023 to 2 August 2023**
Responsible Executive:	**Janette Keenan, Director of Nursing**
Report Author:	**Norma Beveridge, Director of Nursing - Acute Division**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Healthcare Improvement Scotland (HIS) carried out a Safe Delivery of Care (SDoC) Inspection in Victoria Hospital between 31 July and 2 August 2023. This report has been prepared to provide the Clinical Governance Committee with an overview of the inspection and progress against the improvement action plan.

2.2 Background

In November 2021, taking account of the changing risk considerations and sustained service pressures, the Cabinet Secretary for Health and Social Care approved adaptations to the inspections of acute hospitals across NHS Scotland to focus on the **Safe Delivery of Care**.

The inspections consider the factors that contribute to the Safe Delivery of Care. To achieve this, inspectors:

- observe the delivery of care within the clinical areas in line with current standards and best practice.
- attend hospital safety huddles.
- engage with staff where possible, being mindful not to impact on the delivery of care.
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards.
- report on the standards achieved on the day of our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

To support preparation for an inspection and following a letter from HIS Director of Quality Assurance in November 2022 highlighting concerns raised via SDoC Inspections in other Boards, the Acute Services Division (ASD) considered the guidance in the letter regarding aspects of safety and quality. The ASD Senior Leadership Team (SLT) reviewed practice, policies and procedures to assure NHS Fife of learning regarding the issues highlighted in relation to the impact that ongoing system pressures were having on acute care delivery. There was a specific focus on:

- Oversight and supportive leadership
- Collegiate planning
- Overcrowding
- Supplementary staffing
- Staff wellbeing
- Medicines Governance

2.3 Assessment

HIS carried out an unannounced inspection to Victoria Hospital, on Monday 31 July to Wednesday 2 August 2023 using the Safe Delivery of Care methodology and inspected the following areas:

Admissions Unit 1	ward 5	ward 32
Admissions Unit 2	ward 6	ward 41
Children's ward	ward 9	ward 42
Critical Care	ward 22	ward 43
Emergency Department	ward 24	ward 51
National Treatment Centre	ward 31	ward 52
Renal Dialysis unit		

During the inspection the inspection team used the following methodology:

- Inspected the ward and hospital environment.
- Observed staff practice and interactions with patients, such as during patient mealtimes.

- Spoke with patients, visitors, and ward staff
- Accessed patients' health records, monitoring reports, policies and procedures
- Discussion sessions with key members of staff
- Unannounced return visit on Monday 14 August 2023 to follow-up on concerns raised.

This inspection resulted in four areas, two recommendations and nine requirements. The inspectors note the staff they spoke to felt supported and listened to and that staff were responsive to patients' needs. Serious concerns were raised about the condition of the healthcare built environment, Phase 1 which was noted to be in very poor condition. Concern was also raised about the oversight, communication, and escalation processes in relation to the condition of the environment.

The areas of good practice included:

- Hospital safety briefings were well run, structured, inclusive and informative.
- Adult with incapacity care plans were clear, detailed and completed appropriately.
- Safety huddles were inclusive and gave a whole site view.
- Staff take time to reassure patients and carers.

The two recommendations related to:

- NHS Fife should consider including healthcare built environment risks as an item on the Senior Charge Nurse 1:1 discussion template.
- NHS Fife should consider patient dependency and complexity, staff skill mix and professional judgement when declaring 'safe to start'

The nine requirements are detailed below:

1. Take steps to improve the governance, reporting and escalation of critical systems within the built estate.
2. Ensure all sharps box temporary closure lids are in place and hazardous cleaning products are securely stored.
3. Ensure accurate assessment and recording of patients' care needs.
4. Ensure there are effective systems in place to monitor and act on patients' early warning scores.
5. Ensure all staff and volunteers perform hand hygiene at the correct times.
6. Ensure the healthcare built environment is maintained to ensure a safe and clean environment where risks to patient and staff safety are effectively identified and mitigated.
7. Review current domestic service arrangements to ensure sufficient resource is in place.
8. Ensure implantation of effective workforce rostering including real-time staffing.
9. Ensure the dignity of patients is maintained, especially at times of high capacity.

A comprehensive action plan has been agreed by NHS Fife, which was accepted by the HIS Inspection team. An action tracker has been developed to support oversight of progress against the agreed actions

Oversight arrangements to ensure timely progress and to support governance assurance via ASD governance structures into NHS Fife's Corporate Governance was agreed. Acute SLT acts as the core oversight group with IPCT and Estates colleagues invited as temporary substantive members monthly to jointly oversee progress. SLT will then share regular governance reports to ASD Clinical Governance Group and the NHS Fife Clinical Governance Committee.

Much of the focus of the improvement action plan has been directed at improving systems to monitor, manage and maintain the healthcare- built environment and ensuring effective communication of the risk associated with the environment.
Similarly, Infection Prevention and Control have a number of actions related to best practice, training and HAI-SCRIBE which are progressing.
In response to the inspection findings, Acute colleagues took the decision to decant ward 5 ENT from Phase 1 into ward 10 , Phase 2. Ward 5 has since been subject to upgrading and a full scope of improvement works and is on target for completion by 10th March 2024.
Progress with the trial to test an integration with NHS Fife Patientrack (e-obs) and observation machines to automate the recording of results has been slow, most recently delayed by the need for Information Governance documents to be received and presented to Architecture Review Board on the 27th February for approval to proceed with the project.

2.3.1 Quality / Patient Care

The focus of the inspection programme is to assure the Scottish Government of the safe delivery of care. The effective delivery of agreed actions will address the recommendations and requirements and thereby support across all domains of healthcare quality.

2.3.2 Workforce

The inspectors consider staffing levels, escalation and staff well-being as part of the inspection**.**

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

There is a risk to patient care and staff wellbeing if the actions identified are not progressed.

There is a reputational risk to NHS Fife if the risks identified are not progressed within the timescales identified.

The recommendation is that SLT agree to progress ASD actions, and support collective oversight with IPCT and Estates to produce a joint quarterly assurance update for the NHS Fife Clinical Governance Committee to provide clear governance to manage these risks.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed however the actions proposed are in pursuit of safe, effective and quality care for all patients and to ensure NHS Fife maintains safe environments to support accessible and safe delivery for all patients and staff.

2.3.6 Other impact

Potential reputational risk following inspection.

2.3.7 Communication, involvement, engagement and consultation

Involvement of EDG members and ASD SLT.

2.3.8 Route to the Meeting

Not applicable.

2.4 Recommendation

- **Assurance**

Report Contact
Norma Beveridge
Director of Nursing - Acute Division

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**HEPMA Programme Update**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Marie Richmond, Head of Digital Strategic Delivery**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- NHS Board / IJB Strategy or Direction / Plan for Fife
- 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 provides Clinical Governance Committee with an update in relation to the delivery of Hospital Electronic Prescribing and Medicines Administration (HEPMA), including Pharmacy Stock Control (PSC) and Integrated Discharge Letter (IDL) and outlines appropriate details of contract award and next steps for Fife.

The report is provided for the Committee's **assurance**.

2.2 Background

The revised HEPMA Business Case was submitted to the NHS Fife Board and approved in July 2022. Two components made up the contractual requirements; one for the Integrated Discharge Letter (IDL) solution which was to be supplied by Orion Health and the other for HEPMA provided by Careflow Medicines Management (CMM) which is being managed through Change Control within an existing Patient Management Service (PMS) Contract.

The update provided to Clinical Governance Committee on 3rd March 2023, advised that contractual terms in relation to HEPMA were in the process of being agreed, with NHS Fife upholding the highest standards of procurement. The IDL solution however was in the process of being mapped out for delivery.

This paper provides the committee with status of both projects.

2.3 Assessment

HEPMA

NHS Fife completed due diligence and agreed to award the contract via the Patient Management System (PMS) contract in December 2024. Whilst the timeframe to award was longer than originally anticipated committee members can be assured the contract negotiated was awarded with the best interest of Fife at its heart.

There were considerable negotiations in relation to indemnity, liability, financial costs and profiling and the specification for NHS Fife. These points have all been agreed via procurement and financial governance.

In addition to above, two main points of award are outlined below to ensure clinical governance committee members are assured of clinical safety and best practice.

Service Level Agreement

The Service Level Agreements for CMM were standard for Scotland, however digital and pharmacy colleagues were not supportive of these levels. CMM were unwilling to change the SLA for one Board however through negotiation, NHS Fife were able to agree with CMM (providers of HEPMA) to a level of assurance being added to each of the Service Levels which relates to the categorisation of severity.

Each of the severity levels now has additional text which states: -

"The level will be aligned to clinical risk management practice in accordance with DCB-129 Standard (Clinical Risk Management: Its application and manufacture of Health IT Systems)"

This is a benefit to NHS Fife as it allows clinical judgement to be part of the prioritisation process for issues which may occur with the HEPMA or Pharmacy Stock Control systems.

Length of Contract

The original business case for HEPMA was for a contract award of 7 years. As the contract was awarded via the Patient Management System (PMS) framework contract scheduled to end December 2029, the HEPMA Contract was also awarded to meet with this end date, as per best practice. NHS Fife will consider a way forward in advance of the end date.

As part of the contract award for HEPMA, the provider CMM agreed to include a new Pharmacy Stock Control system at no additional cost to NHS Fife. As NHS Fife's current Stock control system was end of life this was accepted by NHS Fife.

The contract negotiations detailed a project start date of January 2024, with a rollout of Pharmacy Stock Control by September 2024 and completion of HEPMA by June 2025. NHS Fife is working with CMM on the overall project plan for delivery and has asked them to work towards improving the scheduled dates for delivery if possible. A further update on timescales will be provided once agreed.

IDL

The Integrated Discharge Letter (IDL) project is currently in progress, unfortunately in December 23 the product failed User Acceptance Testing (UAT) and therefore discussions are ongoing with the supplier Orion to resolve the issues and a new date for delivery is being agreed.

2.3.1 Quality, Patient and Value-Based Health & Care

The full business case for HEPMA clearly outlines the benefits in relation to quality-of-service delivery and patient care which will be realised through the implementation of HEPMA and the new IDL solution. Contract signature and subsequent project timeline negotiations will ensure these benefits are being realised for NHS Fife as soon as possible. Until the system is implemented fully an effective paper-based prescribing and medicines administration systems will remain in place.

2.3.2 Workforce

Circa 3,500 staff will be positively impacted by the implementation of HEPMA. Prescribers, including all medical staff, pharmacists and nurse/AHP Prescribers and Administrators.

The agreed resource profile for NHS Fife has been implemented to ensure safe delivery of HEPMA within NHS Fife. This resource will also be utilised to take forward IDL and PSC. Prior to contract award HEPMA activity was focussed on scoping readiness of areas and delivery of training plans to ensure smooth implementation.

2.3.3 Financial

The funding for HEPMA delivery has been agreed by NHS Fife and Scottish Government. Delays in the signing of the call off contract resulted in negotiations, the digital and finance teams have confirmed the current position with Scottish Government to ensure the funding is preserved.

2.3.4 Risk Assessment / Management

Risks are managed in line with project governance and are reported to the HEPMA Programme Board. There are no risks which require to be highlighted to the clinical governance committee.

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

An impact assessment has been approved and published for HEPMA as a concept on 01 October 2020 by NHS Fife Equality and Human Rights Officer. The Impact Assessments are currently being updated following contract signature.

2.3.6 Climate Emergency & Sustainability Impact

Reduction in the use of paper through implementation of electronic prescribing will contribute positively to the climate emergency and commitment to net zero.

2.3.7 Communication, involvement, engagement, and consultation

- The HEPMA Programme Board have been kept up to date with all contractual elements.
- The Medical Director, Director of Pharmacy and Director of Finance formally signed off contract award.

2.3.8 Route to the Meeting

- The areas outlined within this paper have been discussed with Executive Directors Group and HEPMA Programme Board.

2.4 Recommendation

This paper is provided to members for:

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

Report Contact
Marie Richmond
Head of Digital Strategic Delivery
Email marie.richmond@nhs.scot

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Information Governance and Security Steering Group Update**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy - SIRO**
Report Author:	**Alistair Graham, Associate Director of Digital & Information**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The Information Governance & Security (IG&S) Steering Group, through this report, provides oversight of its work and assurance for the key priorities for the 2023-24 period. The report is the second of two reports for the financial year 2023-24.

The Steering Group continue to support the tasks, activities and projects that are key to the continuous improvement, mitigation of risk and evidence of improved controls for the areas of IG&S.

Following a review of the Information Commissioners Office (ICO) Accountability Framework and the Scottish Public Sector Cyber Resilience Framework (SPSCRF), (which incorporates

the Network Information Security Directive (NISD)), the IG&S Steering Group agreed to a revised Accountability and Assurance Framework, to provide a unified view of the current controls, actions and activities undertaken across NHS Fife as we evidence our performance for compliance. The executive summary of the current IG&S Accountability and Assurance Framework is provided in Appendix 1.

Reporting to the Steering Group covers the following areas: -

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individuals Rights
- Transparency
- Records of processing on a lawful basis
- Contracts and data sharing
- Risks and DPIA
- Records Management and Security
- Breach Response and monitoring

The prioritisation of activities is based on the outcome of the ICO external audit, completed in March 2023, the outcome of the Cyber Resilience Framework audit completed in September 2023, the current risk profile within IG&S, through direct instruction by competent or audit authority or via the guidance of the IG&S Steering Group.

The report is intended to provide **assurance** to the Committee.

2.2 Background

ICO Audit

The Information Commissioner is responsible for enforcing and promoting compliance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA18) and other data protection legislation. Section 146 of the DPA18 provides the Information Commissioner's Office (ICO) with the power to conduct compulsory audits through the issue of assessment notices. Section 129 of the DPA18 allows the ICO to carry out consensual audits.

NHS Fife (NHSF) was audited in March 2023, as part of a wider project looking at data protection compliance across the wider NHS in Scotland (NHSS), consisting of 22 audits of Territorial Health Boards and Special Boards in Scotland. The scope of the audits takes into account the Information Governance leads input regarding current data protection risks identified across NHSS as a whole as well as risks identified from ICO intelligence. A summary report for NHSS was published.

The purpose of the NHSF audit is to provide the Information Commissioner and NHSF with an independent assurance of the extent to which NHSF, within the scope of this agreed audit, is complying with data protection legislation.

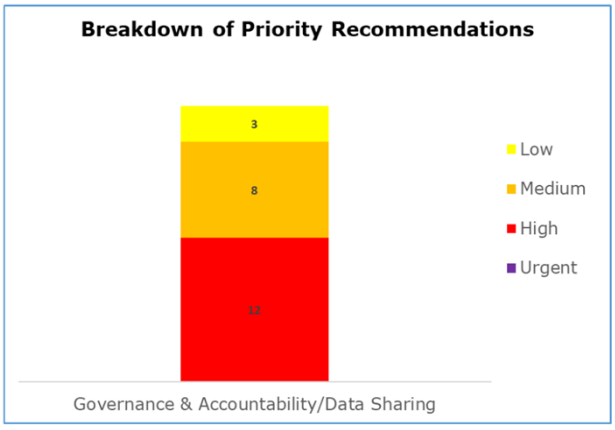
It was agreed that the audit would focus on the following area:

> The extent to which information governance accountability, policies and procedures, and information sharing agreements and logs which comply with the principles of all data protection legislation are in place and in operation throughout the organisation.

The ICO final report provided a rating indicator assessed against four levels of assurance - Very Limited, Limited, Reasonable and High. The summary rating from the ICO, following their audit, indicated a **reasonable assurance** rating for NHS Fife:-

Scope area	Assurance Rating	Overall Opinion
Governance & Accountability/Data Sharing	**Reasonable***	There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation.

The audit report went on to identify 23 action points based on a priority recommendation. The chart below shows a breakdown of the priorities assigned to the ICO priority recommendation: -



The recommendations have now been incorporated into the IG&S Accountability and Assurance Framework report and progress will be monitored by the IG&S Steering Group.

Risk Management

Through work guided by the IG&S Steering Group meetings in January 2023 and April 2023, it was agreed to the use the Board risk appetite description as part of its responsibilities for effective risk management. The steering group considered these descriptors and agreed the following levels of risk tolerance level for categories of risk:-

Risk Category	Tolerance Level
Data Breaches	LOW
Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

This work ensures that IG&S Steering Group can support the risk mitigation activities.

The summary risk position in January 2024 is: -

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	12	2	9	1
Infrastructure	Moderate	6	1	2	3
Access Controls	Moderate	3	0	2	1
Information Assets	Moderate	5	0	4	1
Supplier Management	Moderate	3	0	3	0
Threats and Vulnerabilities	Low	7	1	6	0
Operational Performance	Low	15	9	3	3
Total		**51**	**13**	**29**	**9**

Green risk items within tolerance.
31 risks out with tolerance.

Key Priorities

The IG&S Accountability and Assurance Framework details key areas of action for the year. These have been identified as:-

- Improved Key Performance Measure across areas where limited or no measures exist.
- Continued review of procedures and alignment of the IG&S Accountability and Assurance Framework within policy content.
- Provision of role-based training for staff who have specific IG/Data Protection responsibilities.
- Implementation of Subject Access Requests improvements and single point of contact.
- Development and completeness in the Information Asset Register.
- Implementation of Records Management Plan.
- Delivery of the Action plan following the NISD audit.

2.3 Assessment

Look at each of the priority areas the following can be reported.

Key Performance Indicators
The status of KPIs for each category is detailed below:-

Category	KPI Measures Established	Frequency of Update
Leadership and Oversight	Yes	Annually
Policies & Procedures	Yes	Quarterly
Training and Awareness	Partial	Quarterly
Individual's rights	Partial	Monthly
Transparency	None	Quarterly
Records of processing and lawful basis	Partial	Quarterly
Contracts and data sharing	Partial	Monthly
Risks and DPIAs	Yes	Quarterly
Records Management and Security	None	Monthly
Breach Response and monitoring	Partial	Monthly

The work associated to the establishment of these measures/KPIs will be targeted for completion by April 2024. The mechanism to record and implement may take longer but will form part of the assessment.

Procedure and Policy review
All IG&S Policy documents are within the review period. One Policy will be due for review within the next 6 months. That policy is GP/R4 – Records Management Policy.

One new policy is currently in development to support the work associated with the Data Subject Access Request Policy. This policy is currently being reviewed by stakeholders.

Review the management and implement an improvement plan for Subject Access Requests (SAR)

The improvement work associated with SARs has now concluded, with the revised approach and single point of contact being implemented, on a phased basis, from September 2023. As is indicated in the performance figures within Appendix 1, reporting of SARs performance is greatly improved.

Planned improvement to Information Asset Register and associated Service Catalogue

Work continues to catalogue the remaining information assets in use within NHS Fife, including those that have been mandated nationally.

A key element being considered in this work is the develop of education in support of the role of Information Asset owners and Information Asset Administrators. A procedure is being created in support of this work along with education materials and training.

The establishment of the register will also allow cataloguing of existing contractual arrangements and associated supplier management expectations and work has commenced to include greater availability of information relating to national systems provided by NSS and NES.

Development of project in support of the implementation of Records Management Action Plan

While all 15 areas of the plan are being progressed, focus is being given to the two Amber areas of Business Classification and Audit trail, identified by The Keeper response to the NHS Fife Records Management Plan (January 2023).

A Progress Update Review (PUR) was provided to National Records Scotland in January 2024, allowing National Records Scotland 2 months to comment on progress. The handling of corporate records in paper form, the requirement for a business classification scheme and appropriate retention and destruction processes continues to be a focus.

The improvement project plan is estimated to take 2 years to complete.

NISD Action Plan Implementation

The draft NISD Audit Report (August 2023), reported a compliance level of 87% and increase from the previous year of 76%.

The report states NHS Fife is a high-performing Board, with well-defined security policies and procedures in place.

The current action plan focussed on the following areas identified within the report:-

- Actions to address the remaining 9 urgent recommendations
- Supplier Management
- Asset Management (associated with Information Asset Recording)
- Privileged Access Controls and Network Segregation
- Resilience and Disaster Recovery Testing

Incident Reporting

During the period April 23 to December 2023, 10 incidents were reported to the ICO and/or NISD Competent Authority. During that period 1 incidents was not reported within the

required 72-hour period. Further mechanisms are being developed to ensure there is every opportunity to report a potential breach within the 72-hour period.

At the current time 2 incidents remain active with the ICO and additional information is being provided to support the investigation of the potential breach.

One incident resulted in a reprimand from the ICO. The Information Governance and Security Steering Group will consider this item at its next meeting and provide a specific escalation to the Clinical Governance Committee, through the Executive Directors Group.

2.3.1 Quality, Patient and Value-Based Health & Care

A culture that is supported in understanding its collective and individual responsibilities for Information Governance and Security is necessary to ensure services can consistently provide high levels of care and services and are not impacted by disruption, financial loss or reputational damage.

Within the principals of the overarching privacy programme the rights of the individual (our patients) remain consistent with many of the principles of Realistic Medicine.

2.3.2 Workforce

Many of the activities identify will require NHS Fife to embrace the work and projects associated with improvements. The modelling of approach, consultation and impact to services will be consider via the IG&S Steering Groups, with appropriate escalation to EDG.

The staffing levels within the Information Governance and Security team continue to be reviewed to ensure our compliance with legislation and to ensure the improvement programmes progress. There will continue to be a challenge in maintaining progress against the backdrop of the Re-form, Transform and Perform programmes.

2.3.3 Financial

Some of the activities to mitigate risk and support compliance may incur additional costs.

2.3.4 Risk Assessment/Management

The risk management approach and review has concluded, and the ongoing reporting and mitigation actions forms a standard component of the IG&S Steering Group activities. The group and D&I teams continue to monitor existing and emerging risks.

Many of the actions listed and prioritised have a direct bearing on Corporate Risk 17 – Cyber Resilience, that was presented to the Clinical Governance Committee in January 2024. This risk has a current rating of High.

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

An impact assessment has not been considered in the creation of this report.

2.3.6 Climate Emergency & Sustainability Impact

No other impact considered.

2.3.7 Communication, involvement, engagement and consultation

- Report creation reflects the work undertaken by the IG&S Team, view of the Information Governance Steering Group and associated stakeholders.

2.3.8 Route to the Meeting

This paper has been previously considered by the following groups as part of its development.

- The items contained are considered in detail by the Information Governance and Security Steering Group at their quarterly meeting
- Executive Directors Group (EDG) – 29 February 2024.

2.4 Recommendation

- **Assurance** – The Committee are asked to note the progress being made across the IG&S domains and take assurance from the governance, controls and measures in place.

Assurance Summary

The details of the report, KPIs, progress with the workplans and alignment to external and internal audit allows the following level of assurance to be provided:-

Level of Assurance:			
Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
	Current Level A reasonable level of assurance is provided to the Steering Group.		

3 List of appendices

Appendix 1 – IG&S Accountability and Assurance Framework (Exec Summary) – January 2024

Report Contact

Alistair Graham
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Information Governance and Security Accountability and Assurance Framework

Produced in January 2024

Introduction

The purpose of the ***Information Governance and Security (IG&S) Accountability and Assurance Framework*** is to provide a unified view of the current controls, actions and activities being undertaken across NHS Fife, as we evidence our responsibilities for compliance.

The ***IG&S Accountability and Assurance Framework (IGSAAF)*** is presented to the Information Governance and Security Steering Group on a quarterly basis and is available to all governance committees where appropriate.

The ***IGSAFF*** comprises of the following sections:

I. Executive Summary

a. Report sections and summary of frequency of updates
b. Performance Measures Summary
c. Risk Summary
d. Key Milestones and changes within reporting period

II. Performance Assessment Reports

a. Leadership and Oversight
b. Policies and Procedures
c. Training and Awareness
d. Individuals Rights
e. Transparency
f. Records of processing on a lawful basis
g. Contracts and data sharing
h. Risks and DPIA
i. Records Management and Security
j. Breach Response and monitoring

Section II provides further detail on performance measures relating to existing controls, actions and activities being undertaken for improvement, consideration of existing or emerging risk and a statement of assurance for the IG&S Steering Group to consider.

The prioritisation of activities places greater emphasis on feedback received from external and internal audit, guidance provided by external expert bodies e.g. Information Commissioners Office (ICO), National Cyber Security Centre (NCSC) and National Service Scotland's Cyber Centre of Excellence (CCoE), Internal Audit, internal risk assessment and internal event and breach response themes.

The ***IGSAAF*** has been developed following consultation and feedback from the IG&S Steering Group and following the consideration of a mapping exercise between the **ICO Accountability Framework** and the **Scottish Public Sector Cyber Resilience Framework** (***SPSCRF***) of which the **Network Information Security Directive** (**NISD**) is used as the current audit mechanism by Scottish Government's Competent Authority. The NISD audit only considers 80% of the controls within the ***SPSCRF.*** *

Following review of the mapping exercise it was decided that the core elements identified in the ICO Accountability Framework and Scottish Public Sector Cyber Resilience Framework

** Reference Cyber Resilience Framework V1.2 Section 1 Item 5*

provided key topics to support the continued development of an effective privacy management programme.

The ICO Accountability Framework assess organisations maturity against 10 categories. Each category has several expectations, 77 in total, with a total of 338 controls that organisations are assessed against.

For NISD the domain account is 4, with 17 categories with 101 expectations and 430 controls. New controls are being introduced in the 2023 audit.

The NSID Framework is a component of the overarching Scottish Public Sector Cyber Resilience Framework. Many frameworks exist within the cyber security sector including Cyber Essentials, Cyber Essential Plus and ISO27001, however the SPSCR incorporates best practice and controls from all.

I. Executive Summary

At each meeting, the Steering Group is asked to consider performance targets, controls and improvement actions identified across each of the 10 areas. This section of the report provides a summary of these indicators, where data is available, along with previous performance and where possible, benchmarking.

a. Report sections and summary of frequency of updates

Summary of the Framework Categories: -

Leadership and Oversight	Requirement for clear and documented governance structure in support of the assurance and management of IG&S activities and risks, across all responsible areas of NHS Fife. Key Leadership roles established including, but not limited to, SIRO, Caldicott Guardian, Data Protection Officer/s, Information Security and Cyber Security Manager. Evidence of reporting and assurance
Policies & Procedures	Through a range of policies and procedures, that are reviewed and updated on a regular basis, we can demonstrate visibility to staff and the public of the processes required for data protection, information governance and security. These policies and procedures seek to remonstrate data protection by design and default and ensure strong compliance with security controls in support of SPSCRF.
Training and Awareness	Evidence a considered approach to staff training and awareness programme that is linked to staff members employment lifecycle and role. This includes support for specialised roles, the ability to monitor impact of activities and support awareness raising where risks or incidents require corrective action.
Individual's rights	Consistently inform individuals (staff, patients and patient's representatives) of their rights to access information and have suitable processes and resources to handle just requests in a timely manner. This includes processes to rectify inaccurate or incomplete records and erase or restrict access or processing where individuals request. Individuals are also given access to recognise and respond to individual's complaints about data protection.
Transparency	Transparency helps individuals to exercise their rights and gives people greater control. This is particularly important if the processing is complex or if it relates to a child. Being transparent about what we do with personal data will support data sharing with third parties.
Records of processing and lawful basis	It's a legal requirement to document our processing activities. The main activities in support of this work include Information Asset Registers, associated Data Protection Impact Assessments (DPIAs) and consideration of consent models. The processing of data is easier and less risky when such documents exist and are maintained.
Contracts and data sharing	Through contractual mechanisms and DPIA the legitimacy and requirement to share data is a key consideration. Data sharing agreements are established and maintained and support the development of guidance or procedures. Contracts are required with all processors and a record is kept and maintained.
Risks and DPIAs	We have and maintain ways of identifying and managing risks associated with Privacy and Security. DPIAs are one way to identify risks and high risks, relating to privacy, require reported to the ICO.
Records Management and Security	The implementation of NHS Fife's Records Management Plan is key in supporting the accountability principles and maintain the security of data we create, retain and destroy. How and who access this data is key to maintaining security and this is supported by Business Continuity and disaster recovery plans.
Breach Response and monitoring	The requirement to detect, investigate and record any breaches is fundamental to this category. Personal data breaches can have a range of adverse effects on individuals and to NHS Fife. The requirement to notify the ICO of personal data breaches is 72 hours and is a key measurement in this area.

The reporting frequency for each section and the current availability of measures is noted below: -

Table 1 - Category Relevance, Update Frequency and Measures

Category	Relevant to ICO Accountability Framework	Relevant to NISD/Cyber Resilience Framework	Frequency of Update	Measures Established
Leadership and Oversight	Relevant	Relevant	Annually	Yes
Policies & Procedures	Relevant	Relevant	Quarterly	Yes
Training and Awareness	Relevant	Relevant	Quarterly	Partial
Individual's rights	Relevant	Not Relevant	Monthly	Partial
Transparency	Relevant	Not Relevant	Quarterly	None
Records of processing and lawful basis	Relevant	Not Relevant	Quarterly	Partial
Contracts and data sharing	Relevant	Some Relevance	Monthly	Partial
Risks and DPIAs	Relevant	Relevant	Quarterly	Yes
Records Management and Security	Relevant	Relevant	Monthly	None
Breach Response and monitoring	Relevant	Relevant	Monthly	Partial

We have completed the 2023/24 NISD/Cyber Resilience Framework Audit cycle. Findings and the review of the report, associated actions will be included in the Accountability and Assurance Framework.

b. Performance Measures Summary

Table 2 - Summary Performance Measures

	Information Governance & Security Performance Summary	Target	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23
Operational Performance	Cyber Security - Exposure Score*	< 25	25	24	23	22	25	63	32	45	33	33	29	
	FOI's - Responses within target	85%	90.1%	77.1%	85.0%	84.8%	88.0%	84.9%	78%	86.50%	89%	97.1%	84.4%	
	Number of SARs Received									204	218	226		
	SARs Received (% responded to timeously)	100%	97.4%	98.5% *	100% *	100% *	95.0%	?	?	100%	95.1%	97.3%		
	Information Governance Incidents	Avg 101	97	88	102	145	117	113	120	109	89	96		
	Incidents Reported to ICO or CA		2	1	0	1	0	2	4	2	0	1		
	Incidents Reported within 72 Hours		1	0	0	0	0	2	3	2	0	1		
	Follow up required by ICO		2	1	0	1	0	0	4	2	0	1		
	Mandatory Training Renewal **	80%			49%	50%			54%	54%		59%		
	Annual Measures		**2020**	**2021**	**2022**	**2023**								
	NISD Compliance Status		53%	69%	76%	87%								
	NISD Risk Exposure		13%	8%	3%									
	NISD Controls Completed		53%	58%	64%									
	Public Sector Cyber Resileince Compliance					77%								

Technical Incidents		NIS / GDPR Reportable	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23
	1. Negligible Incidents	N	3394	3800	3119	3383	3753	2934	3865	3622	3919			
	2. Minor Incidents	N		3	1	3	2		3					
	3. Moderate Incidents	Y							1					
	4. Major Incidents	Y												
	5. Extreme Incidents	Y												

* - Scored out of 100; Low 0-29, Med 30-69, High 70-100

** - Only partial information available from SAR teams

*** - Source EDG Training Compliance Report

c. Risk Summary – January 2024

The IG&S Steering Group has agreed to the use of the Board risk appetite description as part of its responsibilities for effective risk management. The following definitions are:-

a) **Low** - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities. (This would be demonstrated by a risk rating less than or equal to 6)

b) **Moderate** - Prepared to accept only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation. (This would be demonstrated by a risk rating that is more than 6 but less than 12)

c) **High** - Willing to consider and / or seek all delivery options (original / ambitious / innovative) and accept those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk. (This would be demonstrated by a risk rating that is more than 12 but less than 20. A risk rating of 20 or 25 being unacceptable for all risks)

D&I will aim to apply the overarching definitions to the risks concerned with its operational responsibilities including IT/Cyber infrastructure.

The IG&S Steering Group has agreed to the following risk tolerance levels for the following categories of risk:-

Table 3 - Risk Category and Tolerance Levels

Risk Category	Tolerance Level
Data Breaches	LOW
Infrastructure	MODERATE
Access Controls	MODERATE
Information Assets	MODERATE
Supplier Management	MODERATE
Threats and Vulnerabilities	LOW
Operational Performance	LOW

The full detail and definitions can be found in the Digital and Information Risk Management Statement.

Summary Risk Position on 22nd January 2024

Table 4 - Summary Risk Position – IG&S Only

Risk Level	Initial Risk Level	Current Risk Level	Previous Period Risk Level (October 2023)
High Risk	18	**8**	**8**
Moderate Risk	11	**17**	**14**
Low/Very Low Risk	0	**4**	**4**
Total	29	**29**	**26**

Three new risks have been identified in the period.

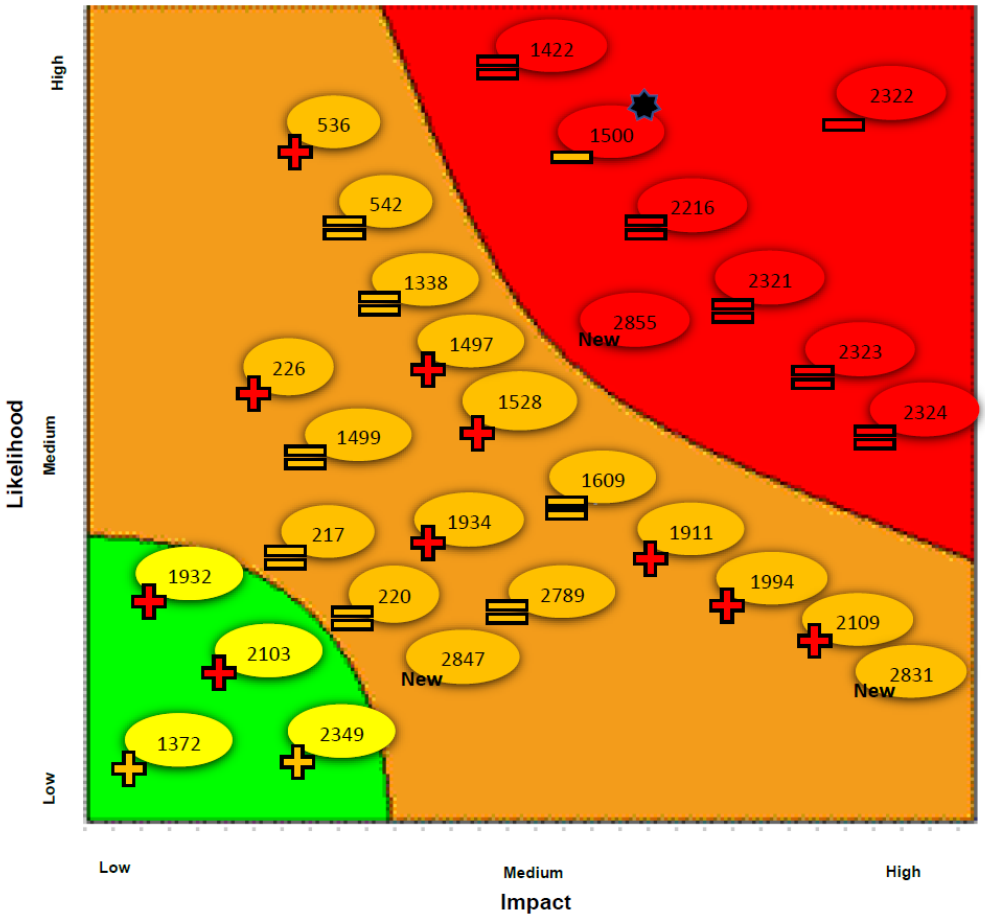
Table 5 - Risk Summary by Category all D&I Risks

Categorisation	Tolerance	Total Risks	Current Risk Level Breakdown		
			High	Moderate	Low
Data Breaches	Low	12	2	9	1
Infrastructure	Moderate	6	1	2	3
Access Controls	Moderate	3	0	2	1
Information Assets	Moderate	5	0	4	1
Supplier Management	Moderate	3	0	3	0
Threats and Vulnerabilities	Low	7	1	6	0
Operational Performance	Low	15	9	3	3
Total		**51**	**13**	**29**	**91**

Green risk items within tolerance
October 2023 – 31 risks out with tolerance.

Figure 1 - Risk Visualisation by Risk Rating

- If the risk status has remained the same it is marked with a
- If the risk has improved its risk level it is marked with a
- If the risk has a deteriorating risk level it is marked with a



d. Key Milestones and changes within the reporting period

Progress in period October 2023 to December 2023.

a) Leadership and Oversight

The Information Governance Operation Group has been re-instated and met on 11th December 2023, which was the first meeting since July 2022. This was as recommended by the ICO Auditors.

b) Policies and Procedures

Presented to EDG in period: -

GP/D3 – Information Governance and Data Protection Policy was reviewed and updated on Blink, with a new Review date of 1st August 2025. The GP/D3 policy on the NHS Fife website is still to be updated. IG&S have followed up again January 2024.

c) Training and Awareness

Mandatory training compliance for IG&S modules has increased to 59% by November 2023. KPIs for measurement confirmed for mandatory compliance and new start compliance. Mechanism for reporting the new start compliance to be developed.

d) Individual Rights

FOI target of 85% was increased to 90% on 1st September 2023. The last 2 months (October and November 2023) saw compliance sitting at 89.3% and 97.1%

Subject Access Request (SAR) revised process has now been operation since September 2023 and proven successful. The organisation has one calendar month to respond to a SAR therefore, requests received in December and January continue to be processed.

Subject Access Requests
(Target – 100% responded to within a month)

	Target	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Number of SARs Received									204	218	226	
SARs Received (% responded to timeously)	100%	97.4%	98.5% *	100% *	100% *	95.0%	?	?	100%	95.1%	97.3%	

Value from the introduction of Single Point of Contact for SARs shown in consistent reporting since introduced in September 2023.

e) Transparency

The ICO Audit provided NHS Fife with actions to undertake in relation to compliance. One of those actions was to ensure that the organisation ensured their transparency information on the Internet was more widely accessible and that the information was accessible to people with reading difficulties and those who spoke other languages.

Work was undertaken by the IG&S Team and Equality and Diversity department, who identified the top seven languages spoken in Scotland, with concentrated focus on Fife. Pricing costs were scoped out and costs averaged £600 per translation. Additionally, the IG&S Team propose creating child and young adult user friendly information regarding data privacy within NHS Fife. Work on this is still on going.

f) Records of processing and lawful basis

The requirements of Article 30 are partially in existence and require further work to improve. This work is captured within the ICO Audit Action Plan also.

g) Contract and data sharing

SLWG established to look at the contract requirements for existing suppliers. Meetings to be arranged with Procurement team representation.

h) Risks and DPIAs

DPIA procedure is out for consultation with stakeholders.
Risk Management framework now established and complete.

i) Records Management and Security

Work ongoing. SBAR updates provided to IG&S Steeting Group.

j) Breach Response and Monitoring

Procedure for determining if an individual should be informed is to be drafted.

IG&S Team discussed with the Risk Management Team possible configuration to Datix to capture any late reported Datixes, however a prompt on date field not possible. The IG&S Team remind staff recording Datixes to do so timeously, if reported after 72hrs.

Assurance Summary

The details of the report, KPIs, progress with the workplans and alignment to external and internal audit allows the following level of assurance to be provided:-

Level of Assurance:			
Substantial Assurance 	**Reasonable Assurance** 	**Limited Assurance** 	**No Assurance** 
	Current Level A reasonable level of assurance is provided to the Steering Group.		

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Emerging issue
- Government policy / directive
- Local policy

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 33% by 31st March 2024)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national timeframe standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

2.3 Assessment

The complaint "complexity scoring" tool to triage complaints and categorise them as low, moderate, or high complexity continues to be tested, and all open stage 2 complaints have been re-categorised. The complexity categorisation score will provide insight into the volume of complex complaints that NHS Fife receives and handles. This will also ensure that all major or extreme complaints are appropriately escalated within the organisation and linked to adverse events or incidents.

With stage 2 complaints, there is now a level of detail that clarifies where each complaint is in the process. Data taken from the week of February 2024 shows delays in the process remain:

- Awaiting statements – 34% (previous 21% at the end of December 2023)
- Final response with Service for comment or approval – 27.41% (previously 57%, at the end of December 2023)
- Ready to draft, drafting or requires PET action – 27% (previously 18% at the end of December 2023)

In the last week of December 2023 (Q3), there were 72 stage 2 complaints in the system, and there are now 62 stage 2 complaints.

Clinical pressures continue to impact performance by obtaining statements and final response approval.

The additional 0.26WTE Bank Patient Experience Support Officer that joined the Patient Experience Team to gather patient feedback in the form of Care Opinion, Lived Experiences, and Participation and Engagement has temporarily stopped due to absence, but hopefully, this will restart soon.

Work with services continues to review new ways of working and understand challenges. The weekly complaint meetings with Acute have been reinstated. Meetings have been established with HSCP (Community Care, Primary and Preventative Care, Complex and Critical Care).

Work is progressing with a Senior Project Manager within the Corporate Project Management Office to assist with streamlining and implementing changes in complaint handling-processes.

The Patient Experience Team has completed an MS Forms questionnaire to understand their challenges and what works well. The Head of Patient Experience and the Senior Project Manager are working together to create an improvement action plan based on the findings of both these questionnaires. Further work is planned to engage with the services.

The Complaint Dashboard provides live complaint data across NHS Fife, highlighting delays and stages of complaints within the complaint handling process. The Dashboard has received good feedback from Services, helping to raise awareness and focus on all open complaints. The next step is to create a further dashboard specifically for the Patient Experience Team to monitor departmental performance and workload.

The Q3 quarterly report has been prepared for the Clinical Governance Committee, which captures information on 'Measuring the Experience' and 'Improving the Experience'. The report provides information on different methods of gathering feedback and, as we emerge from the pandemic, will report on work being taken forward to understand and improve the patient experience.

The report also captures performance data, which is required as part of the Model Complaints Handling Procedure.

Importantly, in line with the Organisational Learning Group, emerging themes, lessons learned, and quality improvement initiatives will be highlighted in future reports.

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work.

2.3.2 Workforce

Workforce planning

The Patient Experience Team establishment continues to be reviewed, examining workload and workforce planning. Understanding the complexity of complaints and the time required to draft a response, for example, will support workforce planning and the model of complaints management.

The team establishment consists of 1.0 WTE Band 7 team leader, 3.6 WTE Band 6 Patient Experience Officers, 1.8 WTE Band 4 Patient Experience Support Officers, and 2.07 WTE Band 3 Patient Experience Administrators.

The new Band 4 Support Officer (0.69 WTE) started in December 2023, and the Band 6 Patient Experience Officers (1.0 WTE) started in January 2024.

The 1.0 WTE Band 4 Administrator (Navigator) post to support administrative, coordination, and data aspects of the complaints handling process has been extended for six months. This role will help to release more time for Officers and help streamline systems and processes.

A retired Band 6 Patient Experience Officer has joined the bank and agreed to support with drafting.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk.

2.3.5 Equality and Diversity, including health inequalities 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

CGC is asked to take assurance from the report that work continues to improve complaints management.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Flashcard
- Appendix No. 2, Patient Experience & Feedback Report Q3

Report Contact

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Patient Experience Flashcard

January 2024

Concerns, Stage 1 and Stage2 complaints:

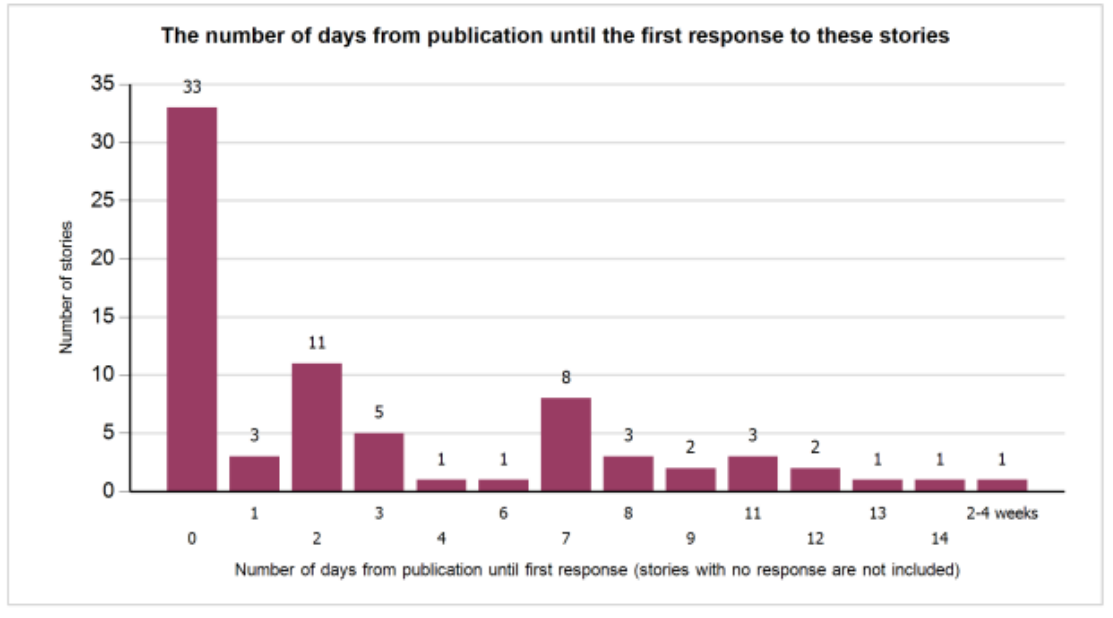
Records logged in Datix Complaints module – 01/07/2022 - 31/12/2023	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Stage 1 Complaint	133	151	139	131	554
Stage 2 Complaint	92	102	87	55	336
Concern	92	124	131	120	467
Enquiry	151	189	210	163	713
Total	468	566	567	469	2070

	22/23 Q4	23/24 Q1	23/24 Q2	22/23 Q3
1	Disagreement with treatment / care plan (49)	Disagreement with treatment / care plan (26)	Co-ordination of clinical treatment (39)	Disagreement with treatment / care plan (27)
2	Staff attitude (22)	Co-ordination of clinical treatment (11)	Disagreement with treatment / care plan (23)	Face to Face (9)
3	Co-ordination of clinical treatment (18)	Face to face (5)	Staff attitude (18)	Co-ordination of clinical treatment (7)
4	Unacceptable time to wait for the appointment / admission (15)	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (12)	Staff attitude (5)
5	Face to face (13)	Staff attitude (4)	Poor nursing care (11)	Poor nursing care (3)

		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
NHS Fife	Opened in Month	26	33	44	42	24	30	26	17	14
	% Acknowledged on time	96.2%	97.0%	93.2%	90.5%	100.0%	100.0%	92.3%	100.0%	100.0%
	Due in Month	38	29	35	43	46	19	30	23	17
	% Closed on time	15.8%	6.9%	17.1%	16.3%	10.9%	15.8%	20.0%	26.1%	5.9%
	Closed in Month	23	36	37	52	54	28	25	40	25
	% Closed on time	26.1%	8.3%	16.2%	11.5%	11.1%	7.1%	24.0%	10.0%	8.0%
Acute	Closed in Month	17.9%	4.8%	22.7%	21.2%	16.7%	21.4%	25.0%	16.7%	6.7%
	% Closed on time	16	27	23	43	36	16	18	14	17
HSCP	Closed in Month	1	1	1	0	0	0	2	2	0
	% Closed on time	10.0%	12.5%	8.3%	0.0%	0.0%	0.0%	14.3%	50.0%	0.0%

Patient Feedback

April – 82 (17 – HSCP) Read 5,200 times
May – 105 (19 – HSCP) Read 5,253 times
June – 171 (5 – HSCP) Read 6,944 times
July – 123 (11 - HSCP) Read 5,253 times
August – 107 (27 - HSCP) Read 6,055 times
September – 109 (30 - HSCP) Read 4,951 times
October – 104 (27 – HSCP) Read 6,409 times
November – 124 (30 - HSCP) Read 9,715 times
December – 71 (15 – HSCP) Read 4,747 times



Compliments	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Acute Services Division - Planned Care & Surgery	91	126	138	127	482
Acute Services Division - Emergency Care & Medicine	22	30	36	37	125
Acute Services Division - Women, Children and Clinical Services	11	23	5	10	49
Community Care Services	41	70	43	59	213
Primary and Preventative Care Services	27	22	29	27	105
Complex and Critical Care Services	6	9	13	7	35
Corporate Directorates	4	1	0	1	6
No value - Miscellaneous	25	15	56	9	105
Total	227	296	320	277	1120

PET updates

SENIOR PROJECT TEAM

- Supporting PET with Quality Improvements for Complaints
- Priority to improve the Complaint Handling Process
- Action Plan created
- MS Forms Questionnaires for staff to be sent out
- Flow chart for SAER's
- New Investigation Template (Statement Memo) (ECD & P&PCS)

WEEKLY PET MEETINGS WITH SERVICES

- Need to arranged Complex and Critical Care
- Excellent Model within CCS and good meeting and use of Dashboard within P&PCS

MONTHLY PET MEETINGS WITH SERVICES

- Acute Meeting (ECD&PCD) Collaborative Working, improvement work, highlight and escalate delays
- Need to set up with H&SCP and W&C

LEARNING FROM COMPLAINTS

- Varying processes for recording evidence of learning
- Capturing and Sharing Organisation Learning

SINGLE POINT OF CONTACT

- Single point of contact with a consistent approach

EARLY RESOLUTION

- Stage 1 – Services to resolve which is improving
- No written response unless last resort
- Stage 2 – offering a meeting prior to response
- Stage 2 – do we really need to offer a meeting after final response letter.

SAER and Complaint Process

- Looking at the process for Complaints and SAER's
- Flow Chart being developed

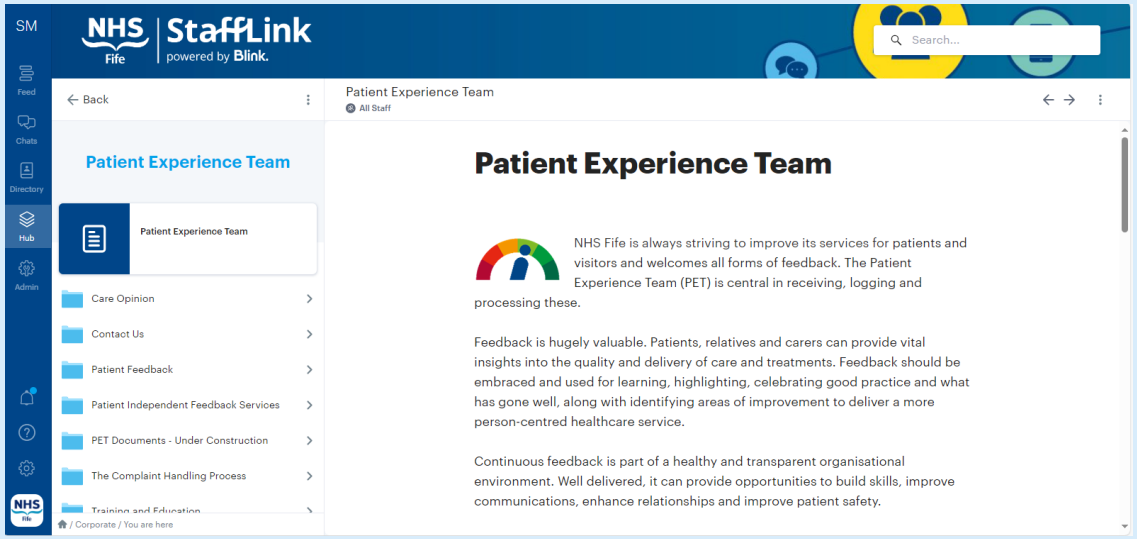
WORKFORCE TOOL

- Review PET Establishment, awaiting national figures

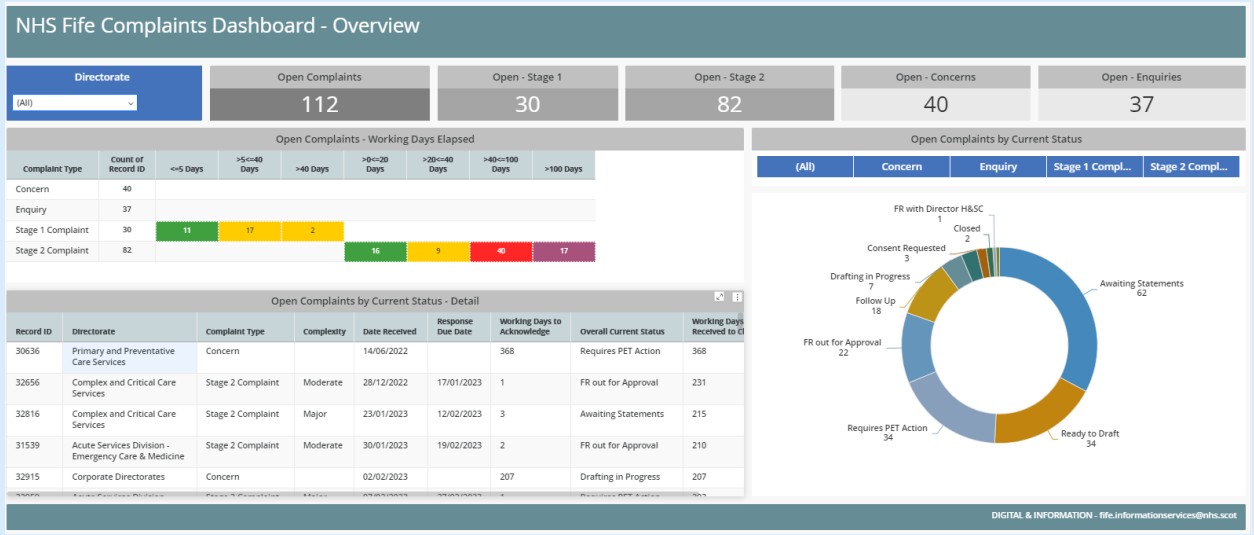
CHALLENGES

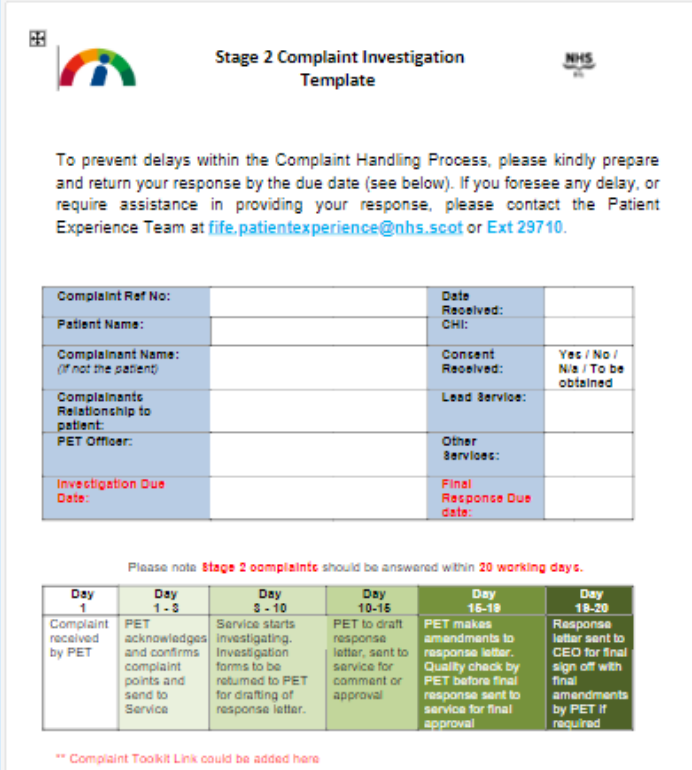
- Delayed statement responses
- Quality of statements
- Multi-directorate complaints
- Delay in approval of final responses
- Lack of continuity in processes
- Inconsistency with SPOC and generic emails

PET updates


SM
NHS Fife | StaffLink
powered by Blink.
Search...
Feed
Chats
Directory
Hub
Admin
← Back
Patient Experience Team
All Staff
Patient Experience Team
Patient Experience Team
Care Opinion
Contact Us
Patient Feedback
Patient Independent Feedback Services
PET Documents - Under Construction
The Complaint Handling Process
Training and Education
/ Corporate / You are here
Patient Experience Team
NHS Fife is always striving to improve its services for patients and visitors and welcomes all forms of feedback. The Patient Experience Team (PET) is central in receiving, logging and processing these.
Feedback is hugely valuable. Patients, relatives and carers can provide vital insights into the quality and delivery of care and treatments. Feedback should be embraced and used for learning, highlighting, celebrating good practice and what has gone well, along with identifying areas of improvement to deliver a more person-centred healthcare service.
Continuous feedback is part of a healthy and transparent organisational environment. Well delivered, it can provide opportunities to build skills, improve communications, enhance relationships and improve patient safety.


Feedback & Complaints Risk Assessmer & Compl
NHS Fife
The Risk Assessment & Complexity Tool categorises the consequences of all types of feedback, including complaint
am (PET) when logging all new feedback & complaints correspondence into DATIX. The PET categorise the risk assessment based on the cont of t
the first instance. Should the clinical teams wish to amend/review the categorisation, this can be done with the relevant PET Officer.
Organisational Learning
Key Themes
Learning from Patient Experience and feedback
Extreme
Adverse Event - Unexpected death or an incident leading to death, intervention required to s life, serious adverse e long-term incapacity, or disability requiring medical treatment &/or counselling.
Complaint - Complaint crosses Acute Services/H&SCPs &/or organisational boundaries. Mu claims or sing MP/MSP/Scottish Government. Complaint length >1250 words. Points of concern raised - > 15.
Organisational/Financial/Reputational Risk - Complaint copied to MP/MSP/Scottish Gov Severe organisational/personal financial loss (£>1m)
Patient Care/Experience - Significant patient safety/quality of care issues. Unsatisfactor tinued ongo
Major
Adverse Event - Major injuries/long term incapacity or disability (loss of limb) requiring medical t
Complaint - Complaint crosses Acute Services /H&SCPs &/or organisational boundaries. Cl management implications, or issues causing lasting detriment that require investigation. Multiple justified 1 - 10 to 15.
Organisational/Financial/Reputational Risk - Complaint copied to MP/MSP/Scottish Government. Proba £1m)
Patient Care/Experience - Significant issues of standards, quality of care or denial of rights. Unsatisfactory p xperience/clin very - >1wk.
Moderate
Adverse Event - Agency reportable, e.g. Police (violent & aggressive acts). Significant injury requiring medical treatment &/o tment &/or counselling, short-term effects.
Complaint – Complaint involves more than one 2 Services. Justified complaint involving lack of appropriate care. Below excess cl rds. Points of concern raised - 7 to 10.
Organisational/Financial/Reputational Risk - Complaint copied to MP/MSP/Scottish Government. Moderate harm to the O e, Significant organisational/personal financial loss (£10-100k) adverse publicity. Category II (HIS).
Patient Care/Experience - Significant issues of standards, quality of care or denial of rights. Unsatisfactory patient experience/clinical outcome, ect reco <1wk.
Minor
Adverse Event - Minor injury or illness, first aid treatment required.
Complaint - Justified written complaint peripheral to clinical care. Complaint length between 500 & 750 words. Points of concern raised - 4 to 6.
Organisational/Financial/Reputational Risk – Minor risk of litigation. Minor organisational / personal financial loss (£1-10k)
Patient Care/Experience - Clinical outcome directly related to care provision – readily resolvable. Unsatisfactory patient experience.
Negligible
Adverse Event - no harm but potential to cause harm e.g. near miss Category III (HIS) or leading to minor injury not requiring first aid.
Complaint - Locally resolved verbal complaint. Complaint length under 500 words. Points of concern raised - 1 to 3.
Organisational/Financial/Reputational Risk - Reduced quality of patient experience / outcome but not directly related to delivery of clinical care. Negligible organisational/personal financial loss (£<1k)
Patient Care/Experience - Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.
[Type here]
Feedback & Complaints Risk Assessment & Complexity Tool
Template Version: 1.0 Date: 7 November 2023
NHS Fife Patient Experience Team
Page 1 of 2
Review Date: 13 September 2025


NHS Fife Complaints Dashboard - Overview
Directorate
(All)
Open Complaints
112
Open - Stage 1
30
Open - Stage 2
82
Open - Concerns
40
Open - Enquiries
37
Open Complaints - Working Days Elapsed
Complaint Type | Count of Record ID | <=5 Days | >5<=40 Days | >40 Days | >0<=20 Days | >20<=40 Days | >40<=100 Days | >100 Days
Concern 40
Enquiry 37
Stage 1 Complaint 30 | 11 | 17 | 2
Stage 2 Complaint 82 | 16 | 9 | 40 | 17
Open Complaints by Current Status
(All) | Concern | Enquiry | Stage 1 Compl... | Stage 2 Compl...
Open Complaints by Current Status - Detail
Record ID | Directorate | Complaint Type | Complexity | Date Received | Response Due Date | Working Days to Acknowledge | Overall Current Status | Working Days Received to Cl
30636 | Primary and Preventative Care Services | Concern | | 14/06/2022 | | 368 | Requires PET Action | 368
32656 | Complex and Critical Care Services | Stage 2 Complaint | Moderate | 28/12/2022 | 17/01/2023 | 1 | FR out for Approval | 231
32816 | Complex and Critical Care Services | Stage 2 Complaint | Major | 23/01/2023 | 12/02/2023 | 3 | Awaiting Statements | 215
31539 | Acute Services Division - Emergency Care & Medicine | Stage 2 Complaint | Moderate | 30/01/2023 | 19/02/2023 | 2 | FR out for Approval | 210
32915 | Corporate Directorates | Concern | | 02/02/2023 | | 207 | Drafting in Progress | 207
FR with Director H&SC 1
Closed 2
Consent Requested 3
Drafting in Progress 7
Follow Up 18
FR out for Approval 22
Requires PET Action 34
Awaiting Statements 62
Ready to Draft 34
DIGITAL & INFORMATION - fife.informationservices@nhs.scot


Stage 2 Complaint Investigation Template
NHS
To prevent delays within the Complaint Handling Process, please kindly prepare and return your response by the due date (see below). If you foresee any delay, or require assistance in providing your response, please contact the Patient Experience Team at fife.patientexperience@nhs.scot or Ext 29710.
Complaint Ref No:
Date Received:
Patient Name:
CHI:
Complainant Name: (if not the patient)
Consent Received:
Yes / No / N/a / To be obtained
Complainants Relationship to patient:
Lead Service:
PET Officer:
Other Services:
Investigation Due Date:
Final Response Due date:
Please note Stage 2 complaints should be answered within 20 working days.
Day 1 | Day 1 - 3 | Day 3 - 10 | Day 10-15 | Day 15-18 | Day 18-20
Complaint received by PET | PET acknowledges and confirms complaint points and send to Service | Service starts investigating. Investigation forms to be returned to PET for drafting of response letter. | PET to draft response letter, sent to service for comment or approval | PET makes amendments to response letter. Quality check by PET before final response sent to service for final approval | Response letter sent to CEO for final sign off with final amendments by PET if required
** Complaint Toolkit Link could be added here

What would make a difference

CONSISTENCY ACROSS ACUTE AND H&SCP

- Weekly complaint meetings
- Single Point of Contact

QUALITY

- Implementation and testing of new Investigation Template (Statement Memo)
- Following the Complaint Handling Process

IMPROVEMENT WORK

- Monthly Complaint meeting to review, delays, processes, quality improvements
- MDT approach to single directorate / multi directorate complaint

EDUCATION AND TRAINING

- PET to offer ad hoc and regular training opportunities

Patient Experience and Feedback

PEaF Quarterly Report (Q3) for Clinical Governance Committee

October - December 2023

CONTENTS

Introduction

Introduction.docx

Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning, and making changes. NHS Fife is the top performing NHS Scotland Board.

NHS Fife's **Care Opinion** highlights for Q3 include:

- **288** stories, viewed **23,243** times in all:
  - October 87 stories
  - November 123 stories
  - December 78 stories

In Q1, Care Opinion moderators rated the stories as:

- Not critical 88% (253)
- Minimally critical 3% (10)
- Mildly critical 5% (15)
- Moderately critical 3% (8)
- Strongly critical 3% (2)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made.

Positive and Negative Themes

What was good?

What could be improved?

Compliments:

Compliments.docx

Compliments	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Compliment	227	296	320	277	1120
Learning from Excellence	0	0	0	0	0
Comments and Feedback	0	3	0	0	0
Total	227	299	320	277	1120

Compliments	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Acute Services Division - Planned Care & Surgery	91	126	138	127	482
Acute Services Division - Emergency Care & Medicine	22	30	36	37	125
Acute Services Division - Women, Children and Clinical Services	11	23	5	10	49
Community Care Services	41	70	43	59	213
Primary and Preventative Care Services	27	22	29	27	105
Complex and Critical Care Services	6	9	13	7	35
Corporate Directorates	4	1	0	1	6
No value - Miscellaneous	25	15	56	9	105
Total	227	296	320	277	1120

Comments:

Emergency Care & Medicine - *A+E Resus On the evening of the 09/10/23 my mother was brought into Victoria hospital A+E Resus from the beeches nursing home. What I witnessed in the care of my mother was outstanding with the team in resus throwing everything at my mother in the attempt to turn things around, never giving up and whilst being incredibly busy always managing a smile along with being extremely polite to me, and explaining each step as it happened.*

Complex & Critical Care Services *– SCN received a letter from patient A thanking the staff in ward 2 for the care and safety they provided whilst patient resided in the ward. Patient also stated that it is clear the NHS in general is spread thin, however despite this, they felt they received excellent care under the staff.*

Planned Care & Surgery *- To all the staff in Ward 31, A very big thank you to one and all for the excellent care & attention given to me over the past 2 weeks. Your help, cheerfulness and wonderful caring have been second to none and I thank you all for all your patience. I consider myself very fortunate to have been in your ward. I am singing your praises and I trust your dedication will always be appreciated by your many grateful patients.*

Community Care Services *– Dear staff at Victoria Hospice Thank you so much for all the care you gave 'patient' and all our family in the hardest time of our lives. Your kindness and care will be remembered by all of us forever. Thank you.*

Complaints:

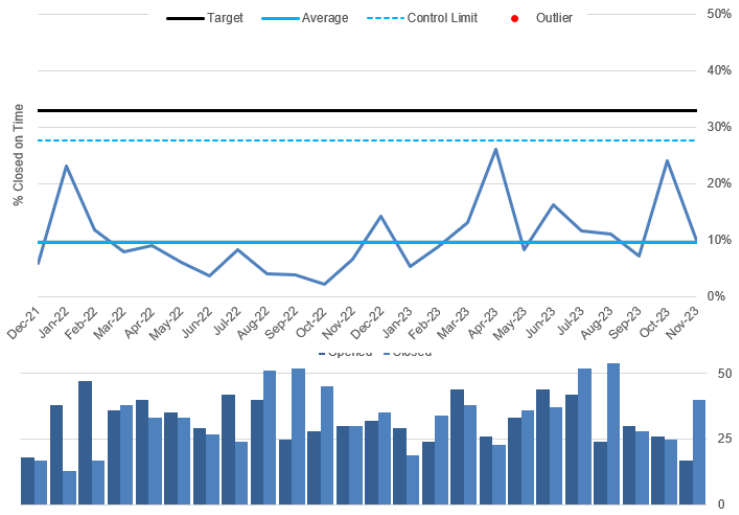
Complaints.docx

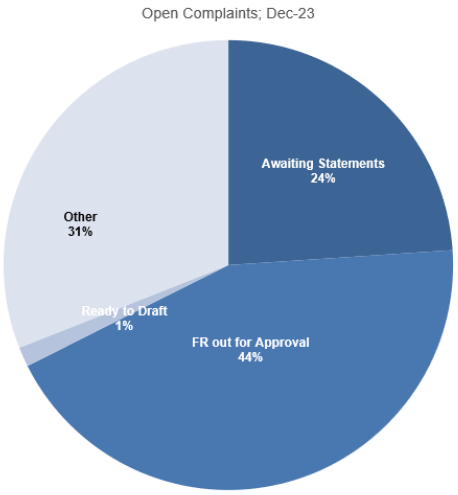
This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 01/07/2022 - 31/06/2023	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Stage 1 Complaint	133	151	139	129	552
Stage 2 Complaint	92	102	87	56	337
Concern	92	124	131	121	468
Enquiry	151	189	210	163	713
Total	468	566	567	469	2070

Stage 2 closed complaints and % closed within the 20-day standard timescale.

CLOSED COMPLAINTS	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total	32	19	34	38	23	33	37	46	51	27	25	40	25
Closed within timescales	4	1	3	5	6	3	6	4	4	2	6	5	2
% Closed within timescales	12.5%	5.3%	8.8%	13.2%	26.1%	9.1%	16.2%	8.7%	7.8%	7.4%	24%	12.5%	8%





Themes

The quarterly ranking of each theme is highlighted in brackets.

	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3
1	Disagreement with treatment / care plan (49)	Disagreement with treatment / care plan (26)	Co-ordination of clinical treatment (39)	Co-ordination of clinical treatment (49)
2	Staff attitude (22)	Co-ordination of clinical treatment (11)	Disagreement with treatment / care plan (23)	Disagreement with treatment / care plan (44)
3	Co-ordination of clinical treatment (18)	Face to face (5)	Staff attitude (18)	Staff attitude (31)
4	Unacceptable time to wait for the appointment / admission (15)	Poor nursing care (5)	Unacceptable time to wait for the appointment / admission (12)	Unacceptable time to wait for the appointment admission (15)
5	Face to face (13)	Staff attitude (4)	Poor nursing care (11)	Insensitive to patient needs (13)

These complaint issues have been addressed at a local level, but Organisational learning must take place to improve practice and to improve the patient experience. The establishment of the Organisational Learning Group will support this endeavour.

Locations receiving most complaints:

1. Mental Health (24)
2. Front Door (20)
3. General Medicine (12)
4. General Surgery (12)
5. Obstetrics & Paediatrics (11)

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 2022	Jul to Sep 2022	Oct to Dec 2022	Jan to Mar 2023	2022/ 2023	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	2023/ 2024
New SPSO cases	3	13	4	5	25	8	7	8		
SPSO decisions	6	4	1	3	14	5	0	3		
SPSO cases fully upheld	1	1	0	1	3	1	0	2		
SPSO cases partly upheld	3	2	0	0	5	0	0			
SPSO cases not upheld	2	1	1	2	6	1	0	1		
Cases not taken forward	6	1	1	0	8	3	0	1		
New SPSO cases this quarter 8					**New SPSO decisions this quarter 3**					

This quarter, 8 new information requests have been received. These relate to the following services:

- Planned Care: 2
- Emergency Care: 4
- Primary and Preventative Care: 1
- Complex and Community Care Services (Mental Health): 1

SPSO Investigation Reports and Decision Reports published on SPSO website, October to December 2023 (Q3):

INVESTIGATION REPORTS	
No.1 SPSO Ref No.	202105840
Month	December 2023
Themes	Care and Treatment; Complaint handling
Outcome	Upheld with 5 Recommendations
Location	VHK – DVT Clinic; Ward 42
Findings	1. There was a failure to appropriately review and monitor C's platelet count at the DVT clinic 2. There was a failure to appropriately assess and diagnose C for suspicion of Heparin Induced Thrombocytopaenia (HIT); provide appropriate haematology advice to medical staff and review and document C's response to pain relief 3. The Board's handling of C's complaint was unreasonable including their handling of the LAER
Recommendations	1. Apologise to C for the failings identified in this report. 2. Bloods results should be appropriately reviewed and patients receiving heparin injections appropriately monitored. Patients should receive appropriate, timely review if any new onset symptoms are reported. 3. Patients presenting symptoms as in C's case should be appropriately reviewed by general and speciality medical staff with reference to the timeframe of onset of symptoms and likely manifestations of HIT, such as stroke, with treatment commenced as appropriate. 4. When an incident occurs that falls within the Duty of Candour legislation, the Board's Duty of Candour processes should be activated without delay and the individual notified within the prescribed timescales. 5. Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. The Board's adverse event policy should be consistent with HIS guidance, and the type of investigation undertaken should be appropriate to the level of category identified. Recommendation – action already taken: The outcome of the local adverse event review had been shared with the key individuals involved for reflection and learning to include improvement in documentation.
Actions	Evidence was submitted to the SPSO, and the complaints reviewer confirmed on 13 February 2024, that all recommendations had been evidenced, with the exception of recommendation 5, part two, which has a deadline of 26 March 2024, and is in relation to the Adverse Events policy.

DECISION REPORTS	
No.1 SPSO Ref No.	202100730
Month	October
Themes	Clinical Treatment; Diagnosis
Outcome	Upheld with Recommendations
Location	VHK OMFS
Recommendations	Offer apology to complainant for failing to reasonably assess and diagnose A's dislocated jaw; findings fed back to staff to inform future decision-making regarding assessment process; referral seen within reasonable timescale. Complaint process – processes should be followed to ensure reporting and learning
Actions	Action plan completed; evidence submitted to SPSO

NHS Scotland Model Complaints Handling Procedure

NHS Scotland Model Complaints Handling

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:

- *The Patient Experience Team works collaboratively with the Adverse Events Team to streamline processes when complaints and adverse events are linked. This will ensure that both processes, although separate and working together to provide a better person-centred focused approach, aim to improve communication and overall complainant/patient/family experience. A draft flow chart has been created to map the proposed process.*

- *A patient was unhappy with the care received within the Urology Diagnostic and Treatment Centre (UDTC). The patient attended for a change of a supra-pubic catheter (SPC), which resulted in the SPC leaking and slight trauma, which required the patient to return to Victoria Hospital for an overnight stay. The patient felt that the staff did not listen to their concerns before discharge earlier that day from the UDTC. Following the complaint, the Senior Charge Nurse (SCN) and Clinical Nurse Specialists in the UDTC are working in collaboration with Practice and Professional Development to review the content of the training and competency framework for SPC changes to ensure it is robust and up-to-date along with reviewing the monitoring of competency skills.*

- *A patient and family felt scared to contact the Patient Experience Team for support and to raise concerns. The SCN has created a board within the ward to promote the use of feedback from patients and to encourage and support an open and safe culture to encourage feedback. They offer an opportunity to*

highlight and share areas for improvement, plus positive feedback from patients, families, and carers. Education sessions for staff with Tissue Viability are to be arranged.

- *A family encountered difficulties when a patient's wound required suctioning and a dressing change. The SCN acknowledged that Nursing staff within the ward had varying experience and skill in caring for complex wounds. The SCN has arranged for training and education sessions with Tissue Viability.*

- *A family encountered difficulties with their sister's stoma care. The SCN has arranged for training and education sessions with the Stoma Team.*

- *Following several incidents and complaints relating to the failures in the handover of care from acute to community settings, a new Short Life Working Group (SLWG) is currently being created, involving staff from the Emergency Care Directorate (ECD), Planned Care Directorate (PCD), District Nursing and Community Hospitals to look at developing pathways for the discharge of a patient from acute. There has been an instance where a patient has been readmitted in Diabetic Ketoacidosis (DKA) due to the failure to communicate and hand over specific care needs relating to insulin administration. Also, another incident where a patient was discharged home but required ongoing wound management and another where the call was made to hand over. However, the District Nursing team had already left the office for the weekend, so the information was missed. The plan is to develop a discharge document that ward staff will use to capture and hand over all relevant information promptly.*

- *Several complaints have raised adverse events, leading to a review of how the service manages these incidents. There have been several cases, one in particular, whereby the complainant has endured months of surgery where we have failed to diagnose fractures. Also, several others where the patient has fallen and broken a hip\wrist etc., but the ward has not escalated. Radiology now attends the monthly Emergency Department meeting so that information is shared between them. I now meet with Radiology every month, and we discuss all issues arising from that month. There has also been a cardiac arrest recently in Radiology that has led to further improvement work around managing a patient post-arrest, but also about the signage and information we share with the Resus teams, especially to the new groups of FY1s as they arrive.*

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.

- *A new Patient Experience Feedback questionnaire has been developed on Microsoft Forms to capture the experience of the person making the complaint in relation to the complaints handling process provided. The questionnaire will be sent out 2 -3 weeks after the complaint response letter. This will allow us to obtain feedback each month by contacting complainants who have opted in. Since starting in January 2023, we have seen an improved response rate on average of 23%. The data will be analysed used to measure and make improvements to the Complaint handling process.*

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q3	12	6	3	Figures provided for NHS, Social work / Fife Council, Voluntary Sector –
	Q4	6	10	4	
	Q1	8	7	1	
	Q2	3	4	1	
Gc half- day intro course	Q3	8	7	5	
	Q4	1	17	4	
	Q1	3	6	4	
	Q2	9	7	2	
Gc Foundation Management		30			
Human Factors		22			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	Q3	122			
	Q4	196			
	Q1	121			
	Q2	141			

Indicator Four: The total number of complaints received

	Q4	Q1	Q2	Q3	Total
4a. Number of complaints received by the NHS Fife Board	225	261	250	236	**972**
4b. Number of complaints received by NHS Primary Care Service Contractors	92	98	N/A	106	**296**
4c. Total number of complaints received in the NHS Board area	**317**	**359**	**250**	**342**	**1268**

Records logged in Datix Complaints module – 01/07/2022-30/06/2023 - Admin	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Stage 1 Complaint	133	151	139	129	**552**
Stage 2 Complaint	92	102	87	56	**337**
Concern	92	124	131	121	**468**
Enquiry	151	189	210	163	**713**
Total	**468**	**566**	**567**	**469**	**2070**

NHS Fife Board - sub-groups of complaints received -

	Q4	Q1	Q2	Q3	Total
4d. General Practitioner	7	15	7	2	**31**
4e. Dental	1	2	1	0	**4**
4f. Ophthalmic	0	0	0	0	**0**
4g. Pharmacy	0	0	0	0	**0**
Total - Board managed Primary Care services	**8**	**17**	**8**	**2**	**35**

	Q4	Q1	Q2	Q3	Total
4h. General Practitioner	47	59	75	81	**262**
4i. Dental	6	9	2	7	**24**
4j. Ophthalmic	0	0	0	0	**0**
4k. Pharmacy	39	39	12	18	**108**
Total – Independent Contractors	**92**	**107**	**89**	**106**	**394**
4l. Combined total of Primary Care Service complaints	**100**	**124**	**97**	**108**	**429**

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)**			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
5a. Stage One	131	144	138	140	59%	76%	78%	76%
5b. Stage two – non escalated	72	37	31	36	32%	20%	18%	20%
5c. Stage two - escalated	20	8	7	7	9%	4%	4%	4%
5d. Total complaints closed by NHS Board	**223**	**189**	**176**	**183**	**100%**	**100%**	**100%**	**100%**

Indicator Six: Complaints upheld, partially upheld, and not upheld -

Stage one complaints	**Number**				**As a % of all complaints closed by NHS Fife at stage one**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
6a. Number of complaints upheld at stage one	31	62	91	83	37%	43%	66%	52%
6b. Number of complaints not upheld at stage one	36	59	29	46	42%	41%	21%	28%
6c. Number of complaints partially upheld at stage one	18	24	16	32	21%	16%	13%	20%

6d. Total stage one complaints outcomes	**85**	**145**	**136**	**161**	**100%**	**100%**	**100%**	**100%**
Stage two complaints **Non-escalated complaints**	**Number**				**As a % of all non-escalated complaints closed by NHS Fife at stage two**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
6e. Number of non-escalated complaints **upheld** at stage two	12	6	5	14	30%	16%	13	32%
6f. Number of non-escalated complaints **not upheld** at stage two	14	18	18	18	35%	49%	47	42%
6g. Number of non-escalated complaints **partially upheld** at stage two	14	13	7	11	35%	35%	18	26%
6h. Total stage two, non-escalated complaints outcomes	**40**	**37**	**30**	**43**	**100%**	**100%**	**100%**	**100%**

Stage two escalated complaints **Escalated complaints**	**Number**				**As a % of all escalated complaints closed by NHS Fife at stage two**			
	Q4	Q1	Q2	Q3	**Q4**	**Q1**	**Q2**	**Q3**
6i. Number of escalated complaints **upheld** at stage two	1	1	3	1	6%	9%	43%	14%
6j. Number of escalated complaints **not upheld** at stage two	13	7	3	5	81%	64%	43%	72%
6k. Number of escalated complaints **partially upheld** at stage two	2	3	0	1	13%	27%	0%	14%
6l. Total stage two escalated complaints outcomes	**16**	**11**	**6**	**7**	**100%**	**100%**	**100%**	**100%**

Indicator Seven: Average times -

	Q4	**Q1**	**Q2**	**Q3**
7a. the average time in working days to respond to complaints at stage one	11.5	7.8	9.6	12
7b. the average time in working days to respond to complaints at stage two	127.7	38.7	36.	50
7c. the average time in working days to respond to complaints after escalation	26	36.7	46.5	78

Indicator Eight: Complaints closed in full within the timescales -

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
8a. Number of complaints closed at stage one within 5 working days.	65	63	65	62	88%	84%	47%	86%
8b. Number of non-escalated complaints closed at stage two within 20 working days	5	10	10	7	7%	13%	32%	10%
8c. Number of escalated complaints closed at stage two within 20 working days	4	2	2	3	5%	3%	21%	4%
8d. Total number of complaints closed within timescales	**74**	**75**	**77**	**72**	**100%**	**100%**	**100%**	**100%**

Indicator Nine: Number of cases where an extension is authorized-

	Number				As a % of complaints closed by NHS Fife at each stage			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
9a. Number of complaints closed at stage one where extension was authorised	16	23	24	47	62%	68%	17%	69%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	10	11	4	21	38%	32%	87%	31%
9c. Total number of extensions authorised	**26**	**34**	**28**	**68**	**100%**	**100%**	**100%**	**100%**

**NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages,
who require Easy Read versions, who speak BSL, read Braille or use
Audio formats.**

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

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

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Medical Education Annual Report 2022/23**
Responsible Executive:	**Dr Christopher McKenna, Medical Director and Responsible Officer**
Report Author:	**Prof Morwenna Wood, Director of Medical Education** **Dr Kim Steel, Associate Director of Medical Education** **Sophie Ali, Medical Education Manager** **Gemma Couser, Associate Director of Quality & Clinical Governance**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The General Medical Council's (GMC) "Promoting Excellence: Standards for Medical Education and Training" became effective on 1 January 2016. NHS Fife is assessed as a Local Education Provider against these standards for medical students and doctors in training on placement.

Requirement 2.2 states:

Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they

are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.

The Medical Education Annual Report provides an overview of:

- Key medical education activity for context and noting.
- Brief benchmarking summary of the top 2% and bottom 2% of departments across Scotland based on trainee surveys.
- Overview of the results of the NHS Education for Scotland (NES) Undergraduate and Postgraduate Surveys 2022/2023.

2.2 Background

Undergraduate Medical Education

NHS Fife hosts medical students from the Universities of Edinburgh, Dundee, St Andrews and Aberdeen in order for them to gain experience and receive teaching in a clinical setting. The Medical Education Department is accountable for the quality of teaching delivered.

Postgraduate Medical Education

NHS Fife has approximately 228 Deanery approved doctor-in-training posts that are part of regional and national training programmes. Supervision of doctors-in-training is carried out by recognised trainers in NHS Fife who must produce evidence of continued development and this role is examined as part of the appraisal process.

2.3 Assessment

Undergraduate Survey 2022/2023
Every year, NHS Education Scotland (NES) produce the undergraduate teaching report. There has been no cause for concern raised and feedback has remained outstandingly good across all programmes, both in primary and secondary care.

Post Graduate Survey 2022/2023
Every year, the General Medical Council (GMC) coordinates the postgraduate survey and the results are available online to the public. The results from the 2022/2023 survey show a mixture of positive and negative feedback across the specialties.

There are local management actions plans that are reported to NES via the Director of Medical Education (DME) Report in relation to feedback from GMC and or NES surveys.

2.3.1 Quality, Patient and Value-Based Health & Care

High quality training is fundamental to ensure sufficient numbers of doctors are trained in Scotland.

2.3.2 Workforce

The delivery of medical education by clinicians is in addition to their direct clinical care activities. Having realistic time in job plans is essential and commitment for this is required

by Clinical Directors. A reduction in the trainee cohort would have significant consequences for many departments.

The Medical Education department is involved in widening access to medicine programs in conjunction with St Andrews. These programs prioritise Fife school pupils in the summer after 5th year of secondary school and during the Easter holidays of 6th year to give them work experience in the NHS. This year there has been over 70 week-long placements over the summer and over 60 pupils through the Easter sessions. It is hoped this improves access to health care careers from schools.

There is an increase in international medical graduates (IMG) joining the organisation. The medical education team have developed a program to welcome IMGs to Fife and ensure that they are orientated to practice in the UK. It is hoped that this approach encourages IMGs to make Fife their new home and join the medical workforce in the longer term.

2.3.3 Financial

Participation in undergraduate medical education attracts funding from NHS Education Scotland (NES) and generates income for the Board. NES provides the basic salary for all trainees, with the board funding payment for their out of hours work.

2.3.4 Risk Assessment/Management

Key risks and mitigation are as follows:

- NES quality assures education and training in our Board and the DME report is an essential part of the Quality Assurance Framework.
- GMC survey is freely available to the public online and poor survey results risks reputational damage.
- Lack of space for medical education is becoming an increasing risk. To enable the department to fulfil the teaching health board status of becoming an integral part of the ScotCOM programme teaching accommodation needs to be extended. There has been an agreement to develop a Medical Education facility at Cameron Hospital and discussions continue with colleagues in the Property and Asset Management Department and in Acute Services around accommodation with VHK.

2.3.5 Equality and Diversity, including health inequalities

Access to medical education is subject to robust equality and diversity protocols, including an initiative to widen access to medical school places from low income families.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

When the results of the Undergraduate Teaching Report and the Scottish Training Survey are released they are shared with key clinical stakeholders for their information and action. The Medical Education Committee meet in February 2023 where results will be reviewed by key educators.

2.3.8 Route to the Meeting

This paper has been developed through engagement with the Medical Education Senior Leadership Team.

2.4 Recommendation

The Clinical Governance Committee is recommended to:

- Examine and consider the content of this report; and
- Take **assurance** in relation the approach taken to ensure the delivery of high quality medical education in NHS Fife

3 List of appendices

The following appendices are included within the Medical Education Annual Report:

- Appendix No 1, Summary of top 2% and bottom 2% of training departments based on training surveys
- Appendix 2, Undergraduate Teaching Report

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Medical Education Annual Report

2022-2023

The purpose of this report is to provide assurance to the NHS Fife Clinical Governance Committee. It will provide an overview of:

- Key medical education activity for context and noting.
- Brief benchmarking summary of the top 2% and bottom 2% of departments across Scotland based on trainee surveys.
- Overview of the results of the NHS Education for Scotland (NES) Undergraduate and Postgraduate Surveys 2022/2023

Introduction

The General Medical Council's (GMC) "Promoting Excellence: Standards for Medical Education and Training" became effective on 1 January 2016. NHS Fife is assessed as a Local Education Provider against these standards for medical students and doctors in training on placement.

Requirement 2.2 of the standard states:

Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.

Background

Undergraduate Medical Education

The Universities of Edinburgh, Dundee, St Andrews and Aberdeen place medical students with NHS Fife in order for them to gain experience and receive teaching in a clinical setting. The number of medical students has been increasing across Scotland for the past three years. Although this report relates to assurances for academic year 2022/2023, the current 2023/2024 numbers are included for context to ensure awareness of capacity and quality issues that are being anticipated and planned for:

	Academic year 2021/22	Academic year 2022/23	Academic year 2023/24
St Andrews	175	175	159
Edinburgh	278	349	412
Dundee	159	165	258
ScotGEM	118	133	164
Aberdeen	8	8	8

NHS Fife is a partner in ScotGEM which is a four-year graduate entry medical programme. ScotGEM is a partnership venture with the universities of St Andrews, Dundee and Highland & Islands and the Health Boards of Dumfries & Galloway, Highland, Tayside and Fife. It is designed to develop doctors interested in a career as a medical generalist within NHS Scotland. The second cohort of doctors graduated from ScotGEM in June 2023.

There was an intentional expansion of numbers to 70 in August 2022 and this has created capacity pressures in 2022/23. Year 1, which began in August 2018, was taught in primary care by GPs called Generalist Clinical Mentors (GCM). NHS Fife currently employs 15 year 1 GCMs, 7 year 2 GCMs, 2 year 3 GCMs and 1 year 4 GCM. These GPs bring 42 clinical sessions to NHS Fife.

This year has seen the partnership working between NHS Fife and the University of St Andrews collaborate to develop a 5-year MBChB programme following on from the recent Scottish Government decision to restore Primary Medical Qualification (PMQ) awarding status to the University of St Andrews. The programme will be tailored to the needs of the NHS in Scotland and will concentrate on delivering community-based medical education that will respond to Scottish Government's priorities.

The new programme will be called Scottish Community Orientated Medicine (ScotCOM). Planning is in the relatively early stages and Medical Education are actively supporting the GMC accreditation progress. The current planning would mean the current year 1 students in St Andrews would transition into being the first ScotCOM cohort in January 2026. As a priority Medical Education would be aligning this with key areas of the strategy including workforce, patient participation and sustainability.

Postgraduate Medical Education

NHS Fife has approximately 228 Deanery approved doctor-in-training posts that are part of regional and national training programmes:

	Training year 2021/22	Training year 2022/23
Foundation	78	82
Core Trainees	43	41
General Practice Trainees	44	39
Higher Specialty	79	66
TOTAL	**244**	**228**

The supervision of doctors is carried out by the Consultant and Specialty Doctor workforce. There are approximately 242 recognised trainers in the organisation that all require to produce evidence of continued development and this role is examined as part of the appraisal process.

Evaluation

Undergraduate Survey 2022/2023

NHS Fife receives feedback from all of the university partners. There has been no cause for concern raised and feedback has remained outstandingly good across all programmes, both in primary and secondary care (Appendix 1)

Positive feedback received from all universities is due to the dedication, enthusiasm and commitment that NHS Fife Local Module Leads have towards undergraduate medical education. There have been a number of our programmes and teachers recognised for their excellence:

Name of Tutor/ Programme	Award
Dr Andrew Storey	Tutor of the Year at the South East Scotland Faculty of Clinical Educators Symposium
Dr Kim Steel	NES Awards – Role Model of the Year Runner Up
St Andrews Emergency Medicine module – Dr Surinder Panpher	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
St Andrews Oncology module – Dr Allie Ramsay	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
St Andrews Old Age Psychiatry module – Dr Katie Paramore	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
St Andrews Rehabilitation module – Dr Lance Sloan	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
St Andrews Sim and exam module – Ms Mo Kermack	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
Dundee Paediatrics – Dr Krishnan Aniruddhan	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
Edinburgh Medicine Yr6 – Drs Andrew Story & Morag Patterson	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
Edinburgh Medicine Yr4 – Drs Stephen Fenning & Nony Mordi	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence
Group awarded to year 3 & 4 ScotGEM GCMs	Scottish Deans Undergraduate Quality Review Panel – recognition of excellence

Post Graduate Survey 2022/2023

The General Medical Council (GMC) coordinates the postgraduate survey and the results are available online to the public. The results from the 2022/2023 survey show a mixture of positive and negative feedback across the specialties. The Director of Medical Education will work with the relevant Clinical Leads in order to develop improvement plans to address any issues. Positive feedback will be celebrated and good practice can be shared.

NES have not released a summary document of all Scottish results so opportunities for benchmarking and collaboration are not currently available.

NHS Fife offers excellent postgraduate training thanks to the efforts of all of our educators. It is important to note that Medical Education do not receive funding for postgraduate trainee doctors and rely on funding from the Board. It is essential that there is commitment from Clinical Directors so that Consultants have dedicated time in their SPA for education, training and supervision. There is also a need for Board commitment for trainee doctors to have dedicated time for wellbeing, quality improvement projects, simulation training, and leadership opportunities.

In terms of both the undergraduate and postgraduate surveys, there are local management actions plans that are reported to NES via the Director of Medical Education (DME) Report in relation to feedback from GMC and or NES feedback surveys.

Governance

With the anticipated developments within Medical Education and the ambition of NHS Fife to become a Teaching Health Board the Medical Director is in the process of revising the governance and reporting on Medical Education activities.

The Medical Director has established a Professional Standards Oversight Group, which will oversee activity relating to medical education in addition to other important issues such as medical and dental recruitment.

This will then report regularly into clinical and staff governance committees. This will ensure the Clinical Governance Committee and the Board are updated more regularly in relation to medical education.

List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of top 2% and bottom 2% of training departments based on training surveys.
- Appendix No 2, Undergraduate Teaching Report.

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Appendix 1

Training Survey Data – combined Scottish Training Survey (STS) and General Medical Council (NTS) Data

The National Training Survey is carried out by NES and each trainee in Scotland is asked to complete a questionnaire to rate their experience across a number of domains. Part of that survey pertains to the department that they have been based in and includes multiple markers of experience such as workload, handover, supportiveness and induction. These domains are then extrapolated to another group of markers to describe the departments training performance for benchmarking purposes and these criteria are described below.

This process means that a department can be inadequate but the best performing of a group of very poorly performing departments and would flag in the top 2% or conversely be highly performing in a group of excellent department and be in the bottom 2%. It is important that this context is understood before too much is attributed to these scores however they are very helpful as a snap shot of where learning can be shared, and support offered, between different areas. To appreciate these results fully, they must always be triangulated with other information about departments to understand the quality of that training workplace.

Top 2%

	Persistent high score	Number of green flags	Good experience across all grades	Significantly High for Specialty	Significant Improvement in Scores
Ophthalmology					
Emergency Department					
General Internal Medicine					
Obstetrics & Gynaecology					
Surgery					
Orthopaedics					

Bottom 2%

	Persistent low score	Number of red flags	Poor Experience across all grades	Significantly low for specialty	Significant reduction in scores
QMH Psychiatry					
Stratheden Psychiatry					
Acute Medicine					
Intensive Care					
Paediatrics					

Appendix No 2, Undergraduate Teaching Report.

2022/23 Detailed Undergraduate Teaching Report: NHS Fife

School	Site	Specialty	Year	Overall Satisfaction	Block Organisation	Treated With Respect	Teaching Delivery	Teaching Quality	Total: Teaching	Learning Opportunities	Clinical Experience	Total: Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total: Support	IT Equipment	Access to Software	Total: IT	Teaching Equipment	Teaching Accommodation	Total: Facilities	Number of respondents
ScotGEM	Adamson Hospital	Medicine of the Elderly	2																						3 (10)
St Andrews	Adamson Hospital	Teaching Clinic	2																						9 (54)
St Andrews	Cameron Hospital	Addiction Services	2																						5 (13)
ScotGEM	Cameron Hospital	Medicine of the Elderly	2																						1 (2)
St Andrews	Cameron Hospital	Rehabilitation Medicine	3	—	—	—		—	—	—		—	—		—	—	—	—							18 (54)
St Andrews	Cameron Hospital	Teaching Clinic	2																						21 (98)
St Andrews	Glenrothes Hospital	Teaching Clinic	2																						16 (70)
St Andrews	Kelty Clinic	Child Development	2																						1 (8)
St Andrews	Levenmouth Drug & Alcohol Project	Health Visiting	2																						8 (30)
St Andrews	Lynebank Hospital	Addiction Services	2																						4 (12)
St Andrews	Queen Margaret Hospital	Anaesthetics/ICU	3																						1 (4)
St Andrews	Queen Margaret Hospital	Breast Surgery	3	—	—	—		—	—	—		—	—		—	—	—	—							15 (59)
St Andrews	Queen Margaret Hospital	Community & Consulting Skills	2																						3 (14)
ScotGEM	Queen Margaret Hospital	Dermatology	2	—	—	—		▲	▲	—		—	—		—	—	—	—	▼	—	▼				11 (27)
St Andrews	Queen Margaret Hospital	Dermatology	3																						5 (15)
St Andrews	Queen Margaret Hospital	ENT	3																						14 (53)
ScotGEM	Queen Margaret Hospital	General Psychiatry	2	—	—	▲		—	—	—		—	—		—	—	—	—	—	▲	▲				8 (34)
ScotGEM	Queen Margaret Hospital	Medicine of the Elderly	2	▲	▲	▲		▲	▲	▲		▲	—		—	—	—	—	▲	▲	▲				8 (14)
ScotGEM	Queen Margaret Hospital	Obstetrics & Gynaecology	2	▼	—	▼		—	—	▲		▲	—		—	—	—	—	—	▼	—				13 (36)
ScotGEM	Queen Margaret Hospital	Ophthalmology	2	—	▼	▲		▼	▼	—		—	▼		▼	—	—	—	—	▼	▼				8 (24)
St Andrews	Queen Margaret Hospital	Ophthalmology	3																						4 (16)
ScotGEM	Queen Margaret Hospital	Paediatrics	2																						5 (7)
St Andrews	Queen Margaret Hospital	Palliative Care	3																						18 (80)
St Andrews	Queen Margaret Hospital	Performance Psychology	2																						23 (129)
St Andrews	Queen Margaret Hospital	Performance Psychology	3																						1 (12)
Edinburgh	Queen Margaret Hospital	Psychiatry	5																						5 (6)
ScotGEM	Queen Margaret Hospital	Simulation	2	▼	—	▼		▼	▼	—		—	—		—	—	—	—	▼	▼	▼				11 (27)

Undergraduate

- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes

This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown regardless of the number of responses available. Figures in brackets are the potential number of respondents. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Trend data: ▲ indicates an improvement in the flag from the previous year, ▼ a deterioration and — no change.

2022/23 Detailed Undergraduate Teaching Report: NHS Fife

School	Site	Specialty	Year	Number of respondents
St Andrews	Queen Margaret Hospital	Simulation and Examination	3	23 (111)
St Andrews	Queen Margaret Hospital	Teaching Clinic	2	15 (76)
ScotGEM	Queen Margaret Hospital	Urgent Care	2	1 (16)
ScotGEM	Queen Margaret Hospital	Urology	2	3 (5)
ScotGEM	St Andrews Community Hospital	Renal Medicine	2	5 (6)
St Andrews	St Andrews Community Hospital	Teaching Clinic	2	15 (88)
St Andrews	Stratheden Hospital	Old Age Psychiatry	3	8 (32)
Dundee	Stratheden Hospital	Psychiatry	4	6 (18)
Edinburgh	Stratheden Hospital	Psychiatry	5	2 (4)
Edinburgh	Stratheden Hospital	Psychiatry	5	8 (10) aggregated
Dundee & ScotGEM	Victoria Hospital	Anaesthetics	D5/S4	2 (9)
Dundee & ScotGEM	Victoria Hospital	Anaesthetics	D5/S4	3 (17) aggregated
St Andrews	Victoria Hospital	Cardiology	2	20 (89)
St Andrews	Victoria Hospital	Cardiology	3	3 (145)
Dundee	Victoria Hospital	Child Health	4	7 (32)
Edinburgh	Victoria Hospital	Child Life and Health	5	9 (17)
St Andrews	Victoria Hospital	Clinical Reasoning	3	14 (64)
ScotGEM	Victoria Hospital	Diabetes	2	3 (8)
ScotGEM	Victoria Hospital	Discharge Hub	2	6 (10)
ScotGEM	Victoria Hospital	Emergency Medicine	2	4 (82)
St Andrews	Victoria Hospital	Emergency Medicine	3	13 (51)
Dundee & ScotGEM	Victoria Hospital	Foundation Medicine	D5/S4	1 (2)
Dundee & ScotGEM	Victoria Hospital	Foundation Surgery	D5/S4	1 (4)
St Andrews	Victoria Hospital	Gastrointestinal	3	4 (22)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes
This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown regardless of the number of responses available. Figures in brackets are the potential number of respondents. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Trend data: ▲ indicates an improvement in the flag from the previous year, ▼ a deterioration and — no change.

2022/23 Detailed Undergraduate Teaching Report: NHS Fife

NHS Education for Scotland

School	Site	Specialty	Year	Overall Satisfaction	Block Organisation	Treated With Respect	Teaching Delivery	Teaching Quality	Total: Teaching	Learning Opportunities	Clinical Experience	Total: Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total: Support	IT Equipment	Access to Software	Total: IT	Teaching Equipment	Teaching Accommodation	Total: Facilities	Number of respondents
Edinburgh	Victoria Hospital	General (Internal) Medicine	4																						13 (12)
Dundee	Victoria Hospital	General Medicine	4	▼	▼		▼	▼	▼	▼	—	▼	▼	▼	▼	▼	▼	▼	—	—	—	—	▼	▼	17 (71)
ScotGEM	Victoria Hospital	General Surgery	2	—	▼	—		—	—	—		—	—		—	—	—	—	—	—	—				4 (27)
ScotGEM	Victoria Hospital	Geriatric Medicine	2																						7 (28)
Dundee & ScotGEM	Victoria Hospital	Intensive Care Medicine	D5/S4																						2 (8)
ScotGEM	Victoria Hospital	Loss	2																						15 (27)
St Andrews	Victoria Hospital	Loss	3	—	▼	—		—	—	—		—	—		—	—	▼	▼							34 (153)
ScotGEM	Victoria Hospital	Medical Orthopaedics	2	▼	▼	—		—	—	▼		▼	—		—	▼	▼	▼	▼	—	▼				4 (12)
St Andrews	Victoria Hospital	Medicine of the Elderly	3	—	—	—		▲	▲	—		—	▼		▼	▼	▼	▼							16 (68)
ScotGEM	Victoria Hospital	Neurology	2																						6 (8)
St Andrews	Victoria Hospital	Neurology	3																						1 (7)
St Andrews	Victoria Hospital	Neurology	3	▼	▲	—							—			—									3 (10) aggregated
ScotGEM	Victoria Hospital	Obstetrics & Gynaecology	2																						6 (18)
Dundee	Victoria Hospital	Obstetrics & Gynaecology	4	▼	—		▼	▼	—	—	▲	—	▲	—	—	—	—	—	—	—	—	—	—	—	9 (26)
Dundee & ScotGEM	Victoria Hospital	Obstetrics & Gynaecology	D5/S4																						1 (4)
Edinburgh	Victoria Hospital	Obstetrics and Gynaecology	5	—	—	▼		▼	▼	▼		▼	—		—	▼	—	▼	—	▼	—				12 (15)
St Andrews	Victoria Hospital	Oncology	3																						20 (78)
ScotGEM	Victoria Hospital	Orthopaedics	2	▼	—	—		▼	▼	—		—	▲		▲	—	—	—	▲	▲	▲				13 (44)
St Andrews	Victoria Hospital	Orthopaedics	3	▼	—	—		▼	▼	▼		▼	—		—	—	—	—							33 (154)
ScotGEM	Victoria Hospital	Paediatrics	2	—	—	—		—	—	—		—	▲		▲	▲	—	▲	—	▲	—				39 (100)
Dundee & ScotGEM	Victoria Hospital	Paediatrics	D5/S4																						2 (8)
ScotGEM	Victoria Hospital	Palliative Medicine	2	—	▼	—		—	—	▼		▼	—		—	—	—	—	▼	▼	▼				14 (27)
St Andrews	Victoria Hospital	Peri-operative Care	3	—	▲	—		▲	▲	▲		▲	▲		▲	▲	—	—							9 (48)
ScotGEM	Victoria Hospital	Rehabilitation Medicine	2																						2 (24)
ScotGEM	Victoria Hospital	Rehabilitation Medicine	2	—	—	—			—	—		—	—		—		—	—	▲	—	—				19 (54) aggregated
Edinburgh	Victoria Hospital	Renal	5	—	▲	▲		—	—	—		—	—		—	—	—	—	—	—	—				7 (16)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes

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2022/23 Detailed Undergraduate Teaching Report: NHS Fife

School	Site	Specialty	Year	Overall Satisfaction	Block Organisation	Treated With Respect	Teaching Delivery	Teaching Quality	Total: Teaching	Learning Opportunities	Clinical Experience	Total: Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total: Support	IT Equipment	Access to Software	Total: IT	Teaching Equipment	Teaching Accommodation	Total: Facilities	Number of respondents
ScotGEM	Victoria Hospital	Renal Medicine	2	▲	▲	▲		▲	▲	▲		▲	–		–	–	–	–	–	–	–				7 (12)
St Andrews	Victoria Hospital	Reproductive Health	3	–	–	–		–	–	–		–	–		–	–	–	–							19 (95)
Edinburgh	Victoria Hospital	Senior Medicine	6	–	▲	–		–	–	–		–	–		–	▲	–	–	–	–					10 (13)
Dundee & ScotGEM	Victoria Hospital	SSC	D5/S4																				▲		6 (20)
St Andrews	Victoria Hospital	Surgery	3	–	▲	–		–	–	▲		▲	▼		▼	–	–	–							16 (70)
Edinburgh	Victoria Hospital	Surgery/Anaesthesia/Critical Care	6	–	▼	–		–	–	–		–	▼		▼	▲	–	▲	–	–	–				9 (14)
ScotGEM	Victoria Hospital	Urgent Care	2																						2 (38)
ScotGEM	Victoria Hospital	Urgent Care	2	–	–	▲		–	–	–		–	–		–		–	–	–	▼	–				8 (78) aggregated
ScotGEM	Victoria Hospital	Urology	2	▼	–	▼		▼	▼	–		–	–		–	▼	▼	▼	–	–	–				4 (17)
ScotGEM	Victoria Hospital	Vascular Surgery	2																						4 (7)
St Andrews	Victoria Hospital	When Organs Fail	3	▼	–	–		–	–	▼		▼	–		–	–	–	–							26 (106)
St Andrews	Whytemans Brae Hospital	Addiction Services	2																						2 (13)
Edinburgh	Whytemans Brae Hospital	Psychiatry	5																						2 (2)
Edinburgh	Whytemans Brae Hospital	Psychiatry	5	–	–	–			▼	–		–	▲		–		▲	▲	–	▲	–				7 (10) aggregated
St Andrews	Whytemans Brae Hospital	Sexual Health	3																						21 (91)

Undergraduate
- Score less than 0
- Score 0 to less than 0.55
- Score 0.55 to less than 1.55
- Score more than or equal to 1.55
- No results available

Notes

This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown regardless of the number of responses available. Figures in brackets are the potential number of respondents. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Trend data: ▲ indicates an improvement in the flag from the previous year, ▼ a deterioration and – no change.

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**1 March 2024**
Title:	**Annual Duty of Candour Report 2022/23**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards**

1 Purpose

This is presented to for:

- Assurance
- Decision
- Discussion

This report relates to a:

- Government policy/directive
- Legal requirement
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Annually there is a requirement for Health Boards to publish an Annual Duty of Candour (DoC) Report. Incidents which trigger DoC are typically identified through the adverse event review process.

2.2 Background

As of 1 April 2018, all health and social care services in Scotland have an organisational Dutyof Candour (DoC). The purpose of organisational DoC is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act and did not relate directly to the natural course of someone's illness or underlying condition. This is a legal

requirement which means that when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to befollowed is set out in the Duty of Candour (Scotland) Regulations 2018.

NHS Fife monitor compliance with the Regulations across the following domains:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Review of reports of the last five Annual Reports indicated the there is still a requirement for each report to include a look back at previous years to ensure completeness. In previous years DoC applied to cases which concluded review after the submission of respective annual submissions and as such these were not represented in the annual report.

2.3 Assessment

There were 33 adverse events requiring DoC with the most common outcome, for 24 patients, being an increase in a person's treatment.

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified including notifying the person and providing details of the incident, provision of an apology, reviewing all cases and offering support and assistance. There was Improvement since last year on providing the patient with a written apology. There was one area identified for improvement and that was arranging a meeting following an offer to meet.

The pandemic and the proceeding years have resulted in delays in the completion of adverse event reviews. In view of the delays in completing adverse event reviews and the commitment to providing a comprehensive annual report it was agreed that the reports should be presented in January each year proceeding the end of the reporting period.

In order to conclude the 2022/2023 annual report the following remain outstanding:

Compliance

- Completion of 1 audit form to assess compliance with DoC Regulations

Adverse Events

- 16 Significant Adverse Event Reviews awaiting submission of final report

- 30 Local Adverse Event Reviews pending

The Adverse Events and Risk Team are working with services to support completion of the outstanding compliance feedback and to conclude adverse event reviews.

Currently for 2023/24 we have 8 confirmed DoC (including 3 falls, 1 each for paediatrics, patient info, personal accident, surgical complication and tissue viability) with 8 outcomes recorded (4 being an increase in treatment). It has again been agreed that the full report should be presented January 2025.

2.3.1 Quality, Patient and Value-Based Health & Care

The learning from adverse event and DoC incidents continues to be a priority. Development of this will be supported through the Clinical Governance Strategic Framework.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

As above, support is in place from the Adverse Events and Risk Team to conclude outstanding compliance feedback and adverse event reviews.

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

This report has been discussed with Dr Chris McKenna, Medical Director.

2.3.8 Route to the Meeting

13th February 2024 – Clinical Governance Oversight Group
15th February 2024 – Executive Directors' Group

2.4 Recommendation

It is recommended that the report contained in Appendix 1 is presented to the Clinical Governance Committee for assurance, discussion and agreement to be presented to the

Board. Any incidents that conclude after submission of the 2022/2023 report will then be included in the 2023/2024 report.

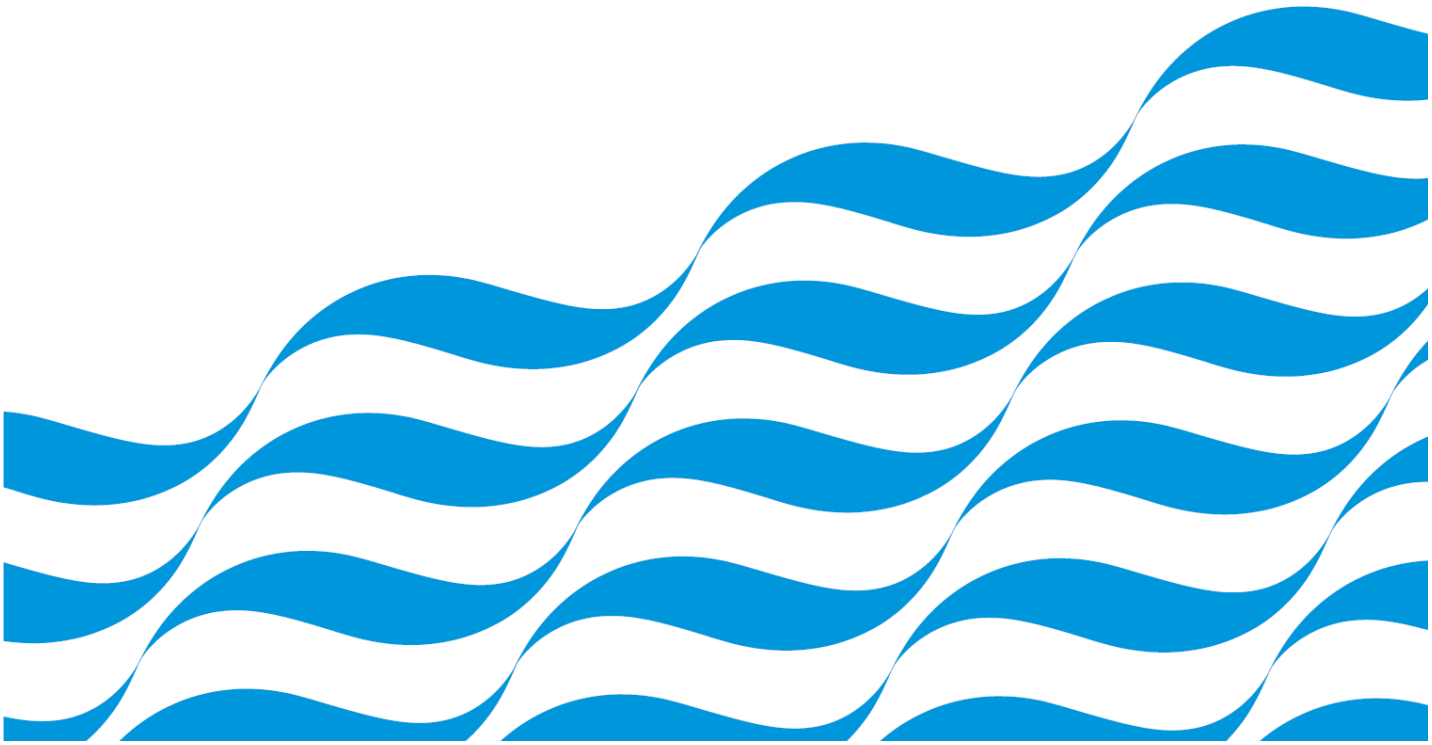
3 List of appendices

The following appendices are included with this report:

- Appendix 1: Annual Duty of Candour Report, 2022/2023

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

Annual Organisational Duty of Candour Report 2022-2023



Contents

1. Introduction and background

NHS Fife

NHS Fife serves a population of approximately 368,000 people. Our vision is to enable the people of Fife to live long and healthy lives. We strive to achieve this by transforming health and care in Fife to be the best.[1]

Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations during the period 1 April 2022 to 31 March 2023 (2022/2023). NHS Fife identified these events mostly through its adverse event management processes. The organisation adopts a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and which is aligned with a national framework[2].

The Covid-19 pandemic and the system pressures in proceeding years has resulted in a delay to the completion of adverse event reviews. This is reviewed regularly with processes in place to ensure reviews are progressed and completed. Consequently there are a number of events reported during this period which are currently under review and which may be reported as activating organisational DoC. It is therefore possible that the number of reported DoC events may be higher than stated in this report. Only those events with a confirmed decision have been included in this report.

A look back at years 1 (2018/2019), 2 (2019/2020), 3 (2020/2021) and 4 (2021/2022) is also included in this report. Previous years are included for completeness as DoC applied to cases which concluded review after the submission of respective annual reports. Also contained in appendix 1-4 are organisational DoC reports from the four health board managed general practices in NHS Fife.

Organisational Duty of Candour

As of 1 April 2018, all health and social care services in Scotland have an organisational Duty of Candour. The purpose of the duty of candour is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition. This is a legal requirement which means that when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to be followed is set out in the Duty of Candour (Scotland) Regulations 2018.

The Organisational Duty of Candour guidance[3] outlines the procedure which must be a followed as soon as reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:

  (a) the incident appears to have resulted in or could result in any of the outcomes below (see Table 1).

  (b) the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

This means if a patient suffers from an unintended or unexpected harm as a result of an adverse event then the following should happen:

- The patient or relative is notified and an apology is offered;
- An investigation is undertaken; and
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation

NHS Fife has an embedded process for the decision making for activating organisational DoC and ensuring all necessary actions are undertaken in accordance with national guidance. On review, any event which is considered to activate duty of candour is escalated to the Board Medical Director for ratification and confirmation of decision. This process is summarised in the following:

- On completion of the investigation the findings and report are offered to be shared with the patient or relative;
- A meeting is offered; and
- Throughout the review and investigation support is to be offered to the people affected which may include staff members involved.

The outcome for organisations is to learn from the investigation and make changes identified as part of the review.

[1] NHS Fife Strategic Framework. 2015.

[2] Learning from adverse events through reporting and review: A national framework for Scotland, revised July2018, NHS Fife review all adverse events.

[3] Organisational Duty of Candour guidance. The Scottish Government. March 2018

2. How many adverse events happened to which the duty of candour applies?

Between 1 April 2022 and 31 March 2023, there were 33 adverse events reported where DoC applied. The main categories of event which activated DoC during this period were:

- [1] Patient Fall
- [2] Tissue Viability
- [3] Other clinical events

Table 1 details the outcomes which were reported across NHS Fife after 1 April 2022 to 31 March 2023.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred 2022/2023
The death of the person	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
An increase in the person's treatment	24
Changes to the structure of the person's body	<5
The shortening of the life expectancy of the person	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	<5
The person requiring treatment by a registered health professional in order to prevent: the death of the person, or any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5

The most common outcome which these events have resulted in is an increase in the person's treatment. This can range from additional antibiotics required to additional night's stay in hospital.

Summary of Years 1-4

Table 2 sets out the events where DoC applied in 2018/19, 2019/20, 2020/21, 2021/22 and 2022/23. This additional information is being included for completeness as DoC was applicable to events which concluded review after respective annual reports were submitted.

The number of events where DoC applied in year 1 is higher than the subsequent years. This can be attributed to the development of learning and understanding of the application of DoC Regulations.

Table 2

Number of Duty of Candour events in each report year	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22	Year 5 22/23
Number of events where DoC applied and where included in respective annual report	46	28	27	36*	33
Number of events where DoC applied and where not included in annual report	10	10	5	5	TBD **
Total number of events where DoC applied	56	38	31	41*	TBD **

*1 event for 3 patients / **To Be Determined (TBD) - Will be included in 23/24 annual report

Table 3 sets out the DoC outcomes for the five-year period. Across this period the most common outcome is an increase in the person's treatment.

Table 3

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred				
	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22	Year 5 22/23
The death of the person	<5	<5	<5	7	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5	<5	<5	<5	0
An increase in the person's treatment	34	21	13	23*	24
Changes to the structure of the person's body	<5	<5	<5	0	<5
The shortening of the life expectancy of the person	<5	<5	<5	<5	<5
An impairment to the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	<5	0	0	0	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days	8	<5	<5	<5	<5
The person requiring treatment by a registered health professional in order to prevent the death of the person, or any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	<5	7	<5	<5	<5

*1 event for 3 patients

3. To what extent did NHS Fife follow the duty of candour procedure?

Of the 33 identified cases, each one was reviewed to assess for compliance with the procedure for the following elements:

- Providing an apology
- Patient and or relative were notified and informed of the adverse event
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting, which is arranged if required
- Giving consideration to support and assistance for the relevant person/ and or staff

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified. These are:

- Notifying the person and providing details of the incident
- Provision of an apology
- Reviewing all cases
- Offering support and assistance

Improvement since last year has been made in:

- Arranging the meeting following offer to meet

Areas for improvement:

- Providing the patient with a written apology

We know that witnessing or being involved in an adverse event can be distressing for staffas well as people who receive care. Support is available for all staff through our line management structures as well as through Staff Wellbeing and Safety.

4. Information about our policies and procedures

Every adverse event which occurs is reported through our local reporting system as set outin our Adverse Events policy and associated processes. Through these, we can identify events that activate the DoC procedure.

The policy contains a section on implementing the organisational DoC, and adetailed section about supporting staff and persons affected by the adverse events, withexamples of the types of support available.

Each adverse event is reviewed to understand what happened and the actions we can take to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the review, and local management teams develop action plans to meet these recommendations.

Clinical teams make the recommendation that Duty of Candour is activated with the final decision made by the Medical Director.

To support implementation of DoC, staff are encouraged to complete the NHS Education Scotland online learning module. This has been made available to staff through TURAS. In addition to the above policy to ensure our practice and services are safe, theorganisation has clinical policies and procedures. These are reviewed regularly to ensure they remain up to date and reflective of current practices. Training and education are madeavailable to all staff through mandatory programmes and developmental opportunities relating to specific areas of interest or area of work.

5. What has changed as a result?

Further to reviews of DoC events in 2022/2023 the following changes have been implemented:

- Care assurance audits on falls and spot checks on falls documentation were carried out to ensure proper procedures are followed for patients at risk of falls.
- Development of a link nurse role with an emphasis on patient falls.
- Falls training was undertaken across many ward areas.
- Learning from falls incidents was shared across ward areas.
- Audits of comfort round completion were undertaken to ensure correct procedure is undertaken for those a risk of pressure ulcers.
- Refresher training in pressure ulcers including skin care, use of 4AT and comfort round assessment was undertaken to improve pressure ulcer management.
- Learning from pressure ulcer incidents was shared.
- The NICE Guidelines on ectopic pregnancy – "when should I suspect an ectopic pregnancy" was shared with Primary Care Management Team to help ensure correct management of ectopic pregnancy.
- A standard operating procedure was developed for follow-up by the sexual health service for those with positive pregnancy tests.
- An administration standard operating procedure was developed to ensure follow-up appointments were arranged for patients from dictated letters.
- The importance of outcoming patients on the electronic TRAK system to ensure a follow-up appointment is organised was emphasised to consultants.
- A system was created that allows patients to make a follow-up appointment before leaving the clinic.
- The NHS Fife Antimicrobial Guideline was updated to include the use of prophylactic antibiotics following excessive blood loss.
- Awareness raising was undertaken within the obstetrics and midwifery team of the risks associated with group B streptococcus on mother as well as baby.
- Education was undertaken on the antimicrobial guidance for the obstetric and midwifery team.
- The NHS Fife anaphylaxis policy is now held within the obstetric guidelines.
- There was education and awareness raising for the obstetric and midwifery team in relation to anaphylaxis and basic life support.

Given the delays described in this report it is anticipated that more changes will be implemented following conclusion of events which are still under review. These will be captured in the 2023/2024 annual report.

If you would like more information about this report, please contact:

Board Medical Director Office
NHS Fife
Hayfield House
Hayfield Road
Victoria Hospital
Kirkcaldy
KY2 5AH
Telephone: 01592 648077

Appendix 1: Linburn Road Health Centre

Linburn Road Health Centre
124 Nith Street
Dunfermline, KY11 4LT
Tel: 01383 733490
Fax: 01383 748758
Email: Fife.F20502LinburnRoad@nhs.scot

Fife Health & Social Care Partnership
Supporting the people of Fife together

Duty of Candour Report

Report period: 1 April 2022 to 31 March 2023

Completed by: Sharon Duncan, Practice Manager

Linburn Road Health Centre provides Health Care to patients within the Dunfermline and Rosyth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2022 and 31 March 2023)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Linburn Road Health Centre follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Kinghorn Medical Practice

Kinghorn Medical Practice
Rossland Place
Kinghorn
Fife
KY3 9RT
Tel: 01592 890217

Duty of Candour Report

Report period: 1 October 2022 to 31 March 2023

Completed by: Fay Paterson, Practice Manager

Kinghorn Medical Practice provides general medical services to around 3360 registered patients residing within the practice boundary which encompasses Burntisland, Kinghorn and the bottom part of Kirkcaldy and some surrounding rural areas. Our mission is to provide a personal quality service making the best use of available resources.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 October 2022 and 31 March 2023)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Lochgelly Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 3: The Links Practice

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF

Tel: 01592 873321

Dr J Yule
M.B.,Ch.B.,D.C.H., M.R.C.G.P.

Fife Health & Social Care Partnership
Supporting the people of Fife together

This short report describes how our care service has operated the duty of candour during the time between 1st April 2022 to 31st March 2023. We hope you find this report useful.

Our Practice serves a population of 1907 patients within the Burntisland, Kinghorn, Aberdour area.

How many Incidents happened to which the duty of Candour applies?

In the last year, there have been no incidents to which the duty of candour applied.

Information about our policies and procedures.

Where something has happened that triggers the duty of candour, our staff report this to the Practice Manager who has responsibility for ensuring that the Duty of candour procedure is followed. The Practice Manager records the incident and reports as necessary to the Health Board. When an incident has happened, the Manager and staff set up a learning review. This allows everyone involved to review what happened and identifies changes for the future.

If you would like more information about The Links Practice, please contact us using these details.

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife
KY3 9JD

Tel: 01592 873321
Email: Fife.F20184LinksPractice@nhs.scot

Appendix 4: Valleyfield Medical Practice

Valleyfield Medical Practice
Chapel Street, High Valleyfield
Fife, KY12 8SJ
Tel: 01383 880511
Email: Fife.F20729valleyfield@nhs.scot

Duty of Candour Report

Report period: 1 April 2022 to 31 March 2023

Completed by: Michelle Parker, Practice Manager

Valleyfield Medical Practice provides Health Care to patients within the High Valleyfield, Low Valleyfield, Culross, Torryburn, Newmills, Cairneyhill and Crossford. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2022 and 31 March 2023)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 5: Methilhaven Medical Practice

Methilhaven Medical Practice
Randolph Wemyss Hospital,
Wellesley Road
Buckhaven KY8 1HU
Tel: 01333 426913
Email: fife.f21505methilhaven@nhs.scot

Duty of Candour Report

Report period: 1 April 2022 to 31 March 2023

Completed by: Linda Johnstone, Practice Manager

Methilhaven Surgery provides Health Care to patients within the Methil, Buckhaven, and Levenmouth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2022 and 31 March 2023)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

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

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

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

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

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Area Clinical Forum

AREA CLINICAL FORUM

(Meeting on 8 February 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Fife NHS Board

Unconfirmed

MINUTES OF THE NHS FIFE AREA CLINICAL FORUM HELD ON THURSDAY 8 FEBRUARY 2024 AT 2PM VIA MS TEAMS

Present:
Aileen Lawrie (Chair)
Jackie Fearn, Consultant Clinical Psychologist
Robyn Gunn, Head of Laboratory Services
Janette Keenan, Director of Nursing
Ailie MacKay, Speech and Language Therapy SLT Operational Lead
Nicola Robertson, Director of Nursing, Corporate
Amanda Wong, Director of Allied Health Professions

In Attendance:
Susan Fraser, Associate Director of Planning & Performance *(item 5.2 & 6 only)*
Tom McCarthy, Portfolio Manager *(item 5.2 & 6 only)*
Lynne Riach, Senior Programme Advisor, Health Improvement Scotland *(item 5.1 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were received from Donna Galloway (Women Children & Clinical Services General Manager), Ben Hannan (Director of Pharmacy & Medicines), Dr Chris McKenna (Medical Director), Dr Susannah Mitchell (General Practitioner) and Emma O'Keefe (Consultant in Dental Public Health).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 7 December 2023

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

The Forum **noted** the updates on the action list.

5. PRESENTATIONS

5.1 Health and Care Staffing Act

The Chair welcomed Lynne Riach, Senior Programme Advisor (HIS) to the meeting. A presentation on the Health & Care Act was provided, and will be shared with the Forum.

Action: Senior Programme Advisor / Board Committee Support Officer

Questions followed and it was advised that there is a Health & Care Staffing website which contains information around the staffing level tools, predominantly nursing & midwifery and all the work that is being undertaken in relation to educational resources. It was also advised that there is a Learning Community Teams channel, which contains further information. The Senior Programme Advisor agreed to share the links to both these resources, and the link to the Knowledge & Skills Framework on TURAS.

Action: Senior Programme Advisor / Board Committee Support Officer

It was advised that the Workforce Lead Teams can provide additional resources, if required, and should be contacted directly.

The challenges with compliance to the legislation were discussed and the Senior Programme Officer offered to contact the Scottish Government for any questions in this area. It was noted that the Scottish Government are not prescriptive in terms of requirements. A request was made to send questions to the Board Committee Support Officer for collating and forwarding on to the Senior Programme Officer.

Action: All / Board Committee Support Officer

Monitoring and compliance for teams was highlighted and the Chair noted that the Forum has a range of multi-disciplinary leads in attendance, who could provide high quality advice. The Chair also requested that the Workforce Lead Team join a future Area Clinical Forum to provide a further update.

Action: Board Committee Support Officer

Discussion took place on the Nursing & Midwifery tools. It was noted that the tools will be further developed, and that this is a timely process due to the various requirements.

5.2 Population Health & Wellbeing Strategy Mid-Year Review

The Chair welcomed Susan Fraser, Associate Director of Planning & Performance and Tom McCarthy, Portfolio Manager to the meeting, who presented on the Population Health & Wellbeing Strategy Mid-Year Review. The presentation will be shared with the Forum.

Action: Portfolio Manager / Board Committee Support Officer

Discussion followed, and it was advised that due to the financial constraints, a realistic review on what can be delivered is being undertaken through the Annual Delivery Plan, and will be linked to the strategy, and will include early intervention and prevention. It was also advised that work is being carried out through the Scottish Government around a target operating model for each speciality. NHS Fife will need to develop a sustainability operating model, and this will be taken forward through the Reform, Transform and Perform Group. It was noted that work is underway for comms to both staff and the public.

The Associate Director of Planning & Performance agreed to join a future Area Clinical Forum to provide an update and to discuss opportunities with members. Questions will be issued in advance for discussion.

Action: Associate Director of Planning & Performance / Members / Board Committee Support Officer

6. QUALITY / PERFORMANCE

6.1 Winter System Review Update

The Director of Nursing advised that this item is now historic and that Winter planning is carried out by the Planning & Performance team. It was reported that a presentation will be provided to the Unscheduled Care Programme Board around Winter performance, which is mainly around cover for public holidays, and that this will be shared at a future Area Clinical Forum.

Action: Associate Director of Planning & Performance / Board Committee Support Officer

6.2 Quality and Improvement Faculty Updates

The Portfolio Manager reported that a draft Quality and Improvement Faculty Annual Report will go through the Clinical Governance Oversight Group before being submitted to the Scottish Government, and will be shared with the Forum.

Action: Portfolio Manager / Board Committee Support Officer

It was reported that a draft workplan is being developed, with the key priorities around education and training.

It was advised that the Scottish Quality & Safety Fellowship are currently recruiting, which is carried out at a national level, and information is available on the staff intranet.

7. GOVERNANCE MATTERS

7.1 Delivery of Annual Workplan 2023/24

The Forum **noted** the tracked workplan.

7.2 Proposed Draft Annual Workplan 2024/25

It was advised that election of the Chair will be added to the workplan for December 2023, as the current Chair's terms ends in February 2025. It was advised that the current Chair is eligible to serve another term, however, election of the Chairperson of the Area Clinical Forum will be an open process, and all Chair members of the Forum may put themselves forward as candidates for the position if they so wish.

7.3 Review of Terms of Reference

The Forum agreed to the comments submitted by the Director of Nursing, Corporate. The Area Clinical Forum Terms of Reference were then **approved** by the Forum.

8. UPDATE FROM EXTERNAL GROUPS

8.1 Area Clinical Forum Chairs Group for Scotland Update

The Chair advised that the main topic for discussion at the recent Area Clinical Forum Chairs Group was around digital solutions, particularly relating to optometrists.

Discussion took place on the shortage of Clinical Scientist Trainees, and around accessing health services within the NHS. It was highlighted that members of the public accessing medical services overseas and privately can have subsequent issues for the NHS, particularly in relation to psychological issues.

9. LINKED MINUTES

9.1 GP Sub Committee held on 21 November 2023 (confirmed) & 16 January 2024 (unconfirmed)

9.2 Area Medical Committee held on 12 December 2023

9.3 Area Pharmaceutical Committee held on 27 November 2023
The Forum **noted** the linked minutes.

10. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no matters to escalate to the Clinical Governance Committee.

11. ANY OTHER BUSINESS

None.

12. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 4 April 2024 at 2pm via MS Teams.**

AREA MEDICAL COMMITTEE (Meeting on 12 December 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Area Medical Committee

CONFIRMED NOTES OF THE AREA MEDICAL COMMITTEE (AMC) HELD ON 12 DECEMBER 2023 VIA MS TEAMS

Present:

Chris McKenna (Chair)	Medical Director
Caroline Bates	CD, Emergency Care Directorate
Fiona Henderson	Fife LMC Honorary Secretary
Glyn McCrickard	Fife LMC Representative
Helen Hellewell	Deputy Medical Director, H&SCP (from 14.35pm)
Ian Fairbairn	CD, Emergency Care Directorate
Jackie Drummond	Interim CD, Complex & Critical Care H&SCP (from 14.23pm)
John Morrice	AMD, Women & Children & Clinical Services
Robert Thompson	CD, Planned Care
Sally McCormack	AMD, Emergency Care & Planned Care

In Attendance:

Emma O'Keefe	Realistic Medicine Team
Kingsley Oturu	Realistic Medicine Team
Catriona Dziech (Notes)	Executive Assistant to Medical Director

Chris McKenna welcomed Emma O'Keefe, Clinical Lead and Kingsley Oturu, Senior Project Manager from the Realistic Medicine Team to give the Committee an update on Realistic Medicine. Following the Realistic Medicine Event on 20 September 2023 the aim of which is to have continued momentum around the values and concept of Realistic Medicine and seek views and ideas from the AMC.

Emma O'Keefe presented a series of slides, which are a repeat from the Workshop but includes the work undertaken to pull the themes together.

Slide 2
In terms of the National agenda, Realistic Medicine, came to light in 2016 and focused around the six principles or pillars, of realistic medicine;

i) shared decision making
ii) Build a personalised approach to care
iii) reduce harm and waste
iv) Tackle unwarranted variation in practice and outcomes
v) Manage risk better
vi) Become improvers and innovators

Following the CMO Annual Reports a seventh principle has been introduced around staff health and well being. This year's report focused on the strategic context of the challenges being faced especially around inequalities and the widening healthy life year

gaps and mentions industrialist healthcare so there may be a move towards processing patients rather than caring for them. There is also narrative around the effect of the Pandemic and the impact of healthcare to recovery and waiting times.

Slide 3
Value Based Health & Care (VBHC) - SGHD published the vision in December 2022 and an Action Plan was produced in October 2023 which aims to use the realistic medicine principles to deliver better outcomes and experiences for the people we care for through equitable, sustainable, appropriate, and transparent use of available resources to help build a more sustainable system.

Before value based healthcare, our key drivers were split into ensuring our systems and policies were aligned to support realistic medicine and equip our workforce with the knowledge and skills to practice realistic medicine and how we empower and ensure the people we are working with are equal partners in care so there is shared decision making, self-management, and promotion of health literacy and healthy lifestyle choices as well.

The workshop on 20 September 2023 was well attended by Clinical Leads and Senior Managers to take stock of where we are in Fife. Catherine Labinjoh from the Realistic Medicine Policy Team was also present with Chris McKenna and Margo McGurk setting the scene for the day. Work was then taken forward through global cafes to challenge us to consider how we embed realistic medicine to ultimately deliver better outcomes for the people we serve. Each global cafe considered seven questions which will feed into our delivery plan.

The Fife Delivery Plan is reported six monthly to the SGHD Realistic Medicine Policy Team. There are also outcomes in the annual delivery plan which also need to be aligned.

Slide 4
Action Plan – By 2025 we will support the Health & Social Care workforce to practice Realistic Medicine, thereby enabling the delivery of high quality and personalised care to the people of Scotland. Feeding into these systems and policies will be aligned to support realistic medicine / VBHC, our workforce will be equipped with knowledge and skills to practice realistic medicine and we will empower and support people to engage with workforce.

Slide 5 - 12
The seven workshops focussed on at the Workshop on 20 September were;
- use resources wisely
- embed Realistic Medicine in education and training
- communicate Realistic Medicine principles effectively
- manage risks better in delivering VBHC
- embed Realistic Medicine in everything we do
- embed Realistic Medicine in governance structures
- encourage local teams to engage with the Atlas of Variation to add value.

Margo McGurk highlighted the need to do things differently and the importance of delivering value and thinking and being mindful that high value and low impact is not a good use of resources. The challenge is to focus discussions on thinking about the total resource envelope and not solely on the financial gap or efficiency savings targets and how to focus energy on developing and realising opportunities to create value for all our patients, workforce, and communities. It is also key to look at how to identify and measure where we have delivered disinvestment or cost improvement to support change.

Emma O'Keefe said she would be keen to hear any ideas around how to think about the whole system and ensure that we are using scarce resources wisely. One example being the work around the cost of missed appointments and in patient bed days which is key to the whole system approach. How do we create cultural shift as well to give permission to stop doing low value and thinking about a patient and patient outcome rather than outputs. Another example that was discussed at the Workshop was around realistic prescribing and looking to re-establish the group that was proactive and got a lot of work done in terms of delivering guidelines, including frailty and looked at the cost of unused medicines, and efficient use of medicines.

Colleagues were present from Health Promotion thinking about to make every opportunity and interaction count to get realistic medicine into the prevention and early intervention strategy being worked on by H&SCP.

Colleagues were present from the Digital & Information team to look at how those resources are also used wisely as well.

There was a table led by Kim Steele looking at embedding principles into Education and Training through;

- combine people and professionals' expertise to share clinical decisions that focus on outcomes that matter
- introduce into school curriculum
- recommended core training – shared decision making
- EC4H and good conversations
- clinical and non-clinical
- patient /public education – what matters to you?

There was a table led by Kirsty McGregor looking at communicating Realistic Medicines principles effectively;

- managing expectations
- how to prioritise workforce, patients, public
- Systems
    - both local and National
    - consistent – patient letters, ACP, KIS
- workforce – internal education and communication
- people – active listening, readiness, language and messaging, health literacy

Emma O'Keefe said a key point going forward was focussing on consistent messaging, whether we write to patients and copy in GPs and other healthcare professionals and to use key information wisely. Active listening is also key and are people ready to have these conversations and be engaged and feel empowered. We also need to ensure the language is appropriate and consistent.

Chris McKenna led a table around Managing Risks better when delivering VBHC. Firstly thinking about doing no harm but be brave and kind at the same time and take a pragmatic, realistic approach to;

- Systems
  - open transparent culture, sharing learning
  - compensation culture – GMC
- Workforce
  - empowering staff to have informed conversations for SDM
  - reduce burden and harm from over investigation and over treatment
  - active treatment does not equal less risk
  - shift from defensive healthcare
- People engaging patients in risk vs benefit conversations

Catherine Labinjoh also led a table around how we embed Realistic Medicine in everything we do;

- System
  - foster culture of stewardship
  - frameworks, strategies, SBARs
- Workforce
  - focus outcomes / impact not outputs
- People
  - BRAN / Questions that matter

Emma O'Keefe highlighted Fife have added an additional questions to the BRAN / questions that matter to include a question around "what more can I do to help myself" which is around self-management and involvement in individual patient care.

Shirley-Anne Savage led a table around embedding RM in governance structures:

- System
  - robust clinical governance processes
  - standard templates
  - supportive organisations
- Workforce
  - compassionate leadership
  - psychological safety
  - reflective practice
  - link with partners
- People – patient experience

Rishma Maini led a table on reducing unwarranted variation in clinical practice to achieve optimal outcomes for patients:

- use of local data for improvement
- knowledge and skills to interpret data
- interface Primary and Secondary Care
- engagement of all staff

Chris McKenna thanked Emma O'Keefe for her comprehensive summary and opened discussion from members on ideas on how we start to move this forward and embed into the organisation.

In taking comment:

Sally McCormack highlighted there are a few operational things that feed into realistic medicine and patient-initiated reviews and is something she has been trying to take forward with various amounts of success with different specialties. The issue has also been discussed at the GP Sub Committee. There is always interface between Primary and Secondary Care, but it feels very patient focussed, and it would be good to tie up realistic medicine with some of the operational issues.

Fiona Henderson said one of the difficulties that remain is the interface between primary and secondary care. GPs may have a very extensive conversations about why they are not going to investigate or why is a bad idea to not give a specific treatment but at the time of Admission changes are made to that. This may be partly because the ability to communicate quickly between primary and secondary care does not exist and feels this one of the biggest areas which needs to be tackled in terms of realistic medicine. Chris McKenna said the conversation needs to be taken to the Public and is on the agenda for 2024.

John Morrice commented these conversations take time and that is perhaps what puts people off because they don't the time to have those conversations. To help embed into our system he suggested including a standing item on the Clinical Governance agenda around how do the principles of realistic medicine impact of our clinical governance activities. Chris McKenna said the plan is to inform Clinical Governance of this work but agreed it does need to become a standard part of routine business.

Robert Thompson commented the general public are principally the reason why realistic medicine does not happen as people's expectations are now are much higher than they were, but doctors come a close second in that we seem to have this principle or thought process that if something is reversible then we should go on and try and reverse it, which isn't always justified or the right thing to do. There are not many conditions that are not reversible in theory with a lot of healthcare input.

In closing going forward Chris McKenna suggested maintaining this item on the AMC agenda by asking Kingsley Oturu to provide an update on activity.

1 APOLOGIES FOR ABSENCE

Apologies were received from Ian MacLeod, Susanna Galea Singer, Morwenna Wood

2 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of interest.

3 MINUTES OF PREVIOUS MEETING HELD ON 10 OCTOBER 2023

The notes of the meeting held on 10 October 2023 were approved.

4 MATTERS ARISING

There were no matters arising

5 STANDING ITEMS

i) Financial Position – Including *(IPQR)*

Chris McKenna said this is a significant issue for the Board with a £23m projected overspend. The driver for the overspend is multifactorial but agency and bank use is definitely a big factor. Some of the historical decisions that were taken within the last three years during the Pandemic have legacy costs and are part of the financial position. This is a National issue, but the Board is accountable for seeking opportunities to balance their books. There are lots of areas where people want to invest to save but these are becoming increasingly difficult arguments to make.

Chris McKenna advised NHS Fife has been escalated to Level 2 of the SGHD finance notice. It is recognised NHS Fife does seem to do more with less resource and that the is still deficit in our NRAC share although the gap is slowing being closed.

Robert Thompson said he had not appreciated trainee doctors salaries are funded by NES so if you have a trainee doctor in post, then the Board only pays the banding of their salary As some departments are not getting the number of trainees, they should have they are having to replace those gaps with clinical fellows, specialty doctor posts or maybe even agency locums, which is a huge increased cost pressure. These costs could be decreased if there was the correct number of trainee doctors allocated as per ratio of population. Chris McKenna said this also meant if we had the right number of doctors rotas would be less likely to become non-compliant and we would not have the other cost pressure which is Band 3 rotas which is an issue across Acute Services.

Chris McKenna said he highlighted the issues to Postgraduate Dean when he visited VHK recently and is committed to try and help with the disparity.

Sally McCormack advised we do very well with very little and this was officially recorded at the debrief for the CFSD Discovery for unscheduled care recognising Fife has less GP's and consultants per head of population than other similar Boards.

Chris McKenna said it would be helpful to see the detail of the data to help understand what investment is required for a substantive medical workforce.

ii) Adverse Events Update – considered at the Clinical Governance Oversight Group

Update noted.

iii) Medical Staff Committee

Phil Walmsley will be chased for an update to Chris McKenna's previous correspondence.

iv) Update from GP Sub Committee

Fiona Henderson the situation in general practice remains difficult. The suggestion of moving care into the community will put more pressure on general practice which is frustrating given the current workload and vacancy rates and day to day pressures being faced.

Chris McKenna said he appreciated the impact of care in the community would have on GPs in an already pressurised service. Fiona Henderson said it was important any proposed changes are discussed with the GP Sub Committee to consider and understand the wider implications.

Sally McCormack suggested it would be helpful if Fiona Henderson could let her and John Morrice know the exact route of communication, she would like information disseminated to as there are various clusters / groups which can sometimes be difficult to navigate. Sally McCormack also suggested working together across Primary and Secondary care to make changes and take things forward in a positive way.

Chris McKenna said it may be helpful to have an Interface type group to discuss issues but would actively encourage more collective working in individual projects. Helen Hellewell said it would be helpful to have more collaboration but the current issue of resources and clinical time on both sides can make it difficult to attend multiple meetings. It may be helpful for any proposed changes being considered to include both the CQLs and GP Sub Committee to look at both the quality and political aspect. It also may be helpful to consider what groundwork requires to be done for any proposed changes, which both sides are happy with.

v) Realistic Medicine

Included in above presentation.

vi) Medical Workforce

Covered briefly in Item 5i above

Robert Thompson advised service fully recruited.

Helen Hellewell advised following a competitive recruitment process Aylene Kelman has been appointed to the position of Associate Medical Director for Primary and Community care. The Clinical Director for Primary Care post will also be going out to advert imminently and Helen Hellewell will ensure this is highlighted to all General Practitioners.

Chris McKenna advised he was pushing the issue of trainee numbers in Fife with NES. This is a complex issue and one he will continue to follow through.

vii) Education & Training

The Committee considered the paper provided by Morwenna Wood on Medical Education and Training and the key issues around:

- Widening Access to Medical & Health Care Careers
- International Medical Graduates
- Expansion of Medical Students
- Increase in Foundation Doctors
- Higher Trainees
- GP Trainees
- Retention

In relation to GP Trainees Helen Hellewell advised she has been working with Kim Steele and Morwenna Wood to look at how to make Fife a more attractive place to work to retain Trainees. It was noted the number of ScotGem GPs has increased in the last few months. Although not a solution to the GP staffing crisis it is hoped in time it may help. This is also the case with the ScotCom programme which is currently on track to begin in January 2026.

John Morrice asked in relation to ScotCom should we be thinking about providing business cases and advertising for posts the ScotCom programme funding will provide. Chris McKenna said we are already aware of what posts are required but different roles apply across Acute and H&SCP. The optimal number of students is 55 which would allow recruitment to all the posts required.

Following discussion, it was agreed it would be helpful to reinstate discussions with NES to consider a Fife GPST training programme which would help retain trainees.

Sally McCormack advised there may be an opportunity that some of the gateway doctors who have undertaken their FY1 and FY2 training in Fife may be interested in undertaking their GPST training in Fife as well.

viii) Update from Division of Psychiatry

The Committee noted Jackie Drummond's update to the Division of Psychiatry.

6 STRATEGIC ITEMS

i) **GMS Implementation**

Following a recent bid four demonstrator sites have been picked. HIS will evaluate what is required in the eighteen months when these sites receive funding. This will only be for two areas of the MOU2 contract (CTAC and Pharmacotherapy). Helen Hellewell agreed to send Chris McKenna the Government paper around implementation and the communication setting out the demonstrator sites.

Helen Hellewell advised during January the gap will be looked at locally to try and sort out the inequity across the services and make sure that sick leave and maternity leave are included to ensure there is good continuous cover.

Glynn McCrickard highlighted this issue was discussed at length at the recent LMC conference. There was widespread dissatisfaction with the government even though there is an openness and willingness work to make things better.

7 ITEMS FOR INFORMATION

i) Notes of the GP Sub Committee: 19 September 2023 & 17 October 2023

Noted.

ii) Notes of the Clinical Governance Oversight Group: 22 August 2023

Noted.

iii) **Notes of NHS Fife Area Drugs & Therapeutics Committee: 16 August 2023**

Noted.

8 AOCB

i) Integrated Planned Care Interface Group

Glynn McCrickard advised he will be attending the Integrated Planned Care Interface Group which is headed up by Chris Conroy and Ashley Bertie. This group currently looks at rejected and bounced back referrals and he has asked that the minutes and correspondence are fed to the GP Sub Committee and this meeting.

9 DATE OF NEXT MEETING

Tuesday 13 February 2024 at 2pm via MS Teams

CANCER GOVERNANCE & STRATEGY GROUP (Meeting on 11 January 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Unconfirmed Note of the Meeting Held at 14:00 on Thursday 11th January 2024 via Microsoft Teams

Present:	**Designation:**
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
Rishma Maini (RM)	Consultant - Public Health
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
John Robertson (JR)	Lead Cancer Clinician - Surgery
Shirley-Anne Savage (SAS)	Associate Director of Quality and Clinical Governance
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Fiona Towns (FT)	Patient Representative
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
Paul Bishop (PB)	Head of Estates
Nicky Connor (NC)	Director Health and Social Care
Izzy Corbain (IC)	Patient Representative
Fiona Forrest (FF)	Deputy Director of Pharmacy
Ben Hannan (BH)	Director of Pharmacy & Medicines
Alistair Graham (AG)	Associate Director Digital and Information
Linda McGourty (LMcG)	GP
Neil McCormick (NM)	Director of Property and Asset Management
Margo McGurk (MMcG)	Director of Finance and Strategy
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
Nicola Robertson (NR)	Director of Nursing, Corporate
In Attendance:	**Designation**
Hazel Close (HC)	Head of Pharmacy
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)
Vanishree Rao (AL)	Consultant – Obstetrics and Gynaecology
Justin Yeo (JY)	Consultant – ENT

		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 2 November 2023 via Microsoft Teams**	
	The Unconfirmed Note of 2 November 2023 was **accepted** as an	

		Action
	accurate record.	
3.	**Action Log**	
	310523#2 – Will be discussed under the appropriate agenda item. This action can be closed.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	CD advised the last meeting was held on the 6th of December. It was noted that changes were made to the terms of reference. The group aims to meet by the end of January, and Jane Anderson, Radiology Manager, will be asked to join. The CWT and performance was discussed along with the issues and barriers that we continue to face. The effective breach analysis guidance has been incorporated in the Management of patient referred urgent suspected or diagnosed with cancer SOP which was signed off for by the NHS Fife Policy Group. CD noted there were good discussions on pathways at the meeting.	
4.2	**Cancer Risks**	
	Papers were shared with the group on cancer risks. The number of risks on the Cancer Risk Register is unchanged (11). There have been no changes to risk rating and level since the last report. There are 5 high level risks and 6 moderate level risks. No risks have achieved its target, and no risks have been closed since the last report. *Operational Risks* CD advised the first 4 operational risks are going to be removed, renewed or re-baselined as they are now so long in duration they are no longer risks, they are actually issues. CD advised she met with Pauline Cumming and all the general managers, and the managers have taken away the actions to address those 4 risks. CD noted the main risk is the CWT risk and there are multiple reporting routes for this particular risk. CM noted he is content the operational risks are held by the service and the reporting would be through the Acute Cancer Services Delivery Group. CM advised for this group, we will focus on the more strategic risks. *Cancer Framework Strategic Risks*	

		Action
	SAS advised Cancer Framework risks are have been agreed. The risks are now in the Datix system. SAS noted that review dates have been allocated to align with the Cancer Governance and Strategy Group. CM advised there will be a role for this group to scrutinise these risks.	
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Annual Delivery Plan Year 2 Update**	
	A SBAR was circulated to assure the group that the Cancer Framework Delivery Plan is robustly monitored based on a recent query raised at the Clinical Governance Committee. KN advised a monitoring spreadsheet allows us to monitor progress against the actions agreed for year 2, 2023-24. KN noted she is awaiting updates from the leads and will bring a year end overview to the next meeting. There have been no responses to date and KN asked the group to respond by the deadline date. KN advised as an overview of where we are in working towards the commitments agreed in the Framework, KN has included year 1 and year 2 actions to date. Planning and engagement to support the Cancer Framework actions for 2024-25 will begin shortly.	
5.2	**Projects Update**	
	Community Pharmacy HC went through the paper that was shared with the group. Alongside the current work to enable the supply of SACT (enzalutamide) via community pharmacy, it is proposed to take forward two main strands of work to develop the role of community pharmacy teams in the earlier detection of cancer: • Increasing confidence and competence of community pharmacy teams in the recognition of early warning symptoms of cancer and recognition of potential side effects of treatment. To achieve this an education session will be delivered early 2024. • Investigation into developing future referral pathways (including the potential to refer to Rapid Cancer Diagnostic Service- RCDS) particularly in areas of high deprivation. As well as the two strands of work outlined above, they will continue to seek opportunities for community pharmacies in Fife to become involved in innovative work to support cancer patient's journeys. Community pharmacy teams are in the unique position of potentially	

		Action
	seeing a cancer patient at every stage of their journey from initial symptoms and diagnosis, through treatment and unfortunately in some cases at end of life treatment. It is therefore important that we support community pharmacy teams to feel confident in caring for this patient group. All of the work will support patient care, improving the confidence of community pharmacy teams in early detection, treating side effects of cancer treatments closer to home and in the future offering quicker referral routes and potentially some treatments in the community setting. All of this work seeks to improve the quality of care patients receive from their community pharmacy. *RCDS Expansion* MM advised the group a SBAR went to the Senior Leadership Team in December and it was well received. An additional 6 months of funding has been given from the Scottish Government, and the acute are sourcing an additional 6 months funding to support this project through to the end of March 2025. In December they received the draft evaluation by the University of Strathclyde. This is not for further circulation at this time as it was recognised that more work is required. Once an update has been received, it will be shared with the appropriate groups. MM advised you can see from the paper shared with the group, we have had over 2,000 referrals, and over 1,000 patients have completed the pathway. *RADC Update* A highlight report was shared with the group regarding the funding that was received from CRUK. RADC commenced on the 15th of August 2023; the clinic has now seen in excess of 100 patients. The achievements of the RADC are: • It is being held twice a week on Mondays and Thursdays, patient appointments levels are increasing. • The 100th patient was seen by the lead nurse of the project in clinic this month. • Co-sponsorship agreement has now been signed off by R&D at NHS Fife and Stirling University. Stirling University will now invoice NHS Fife for monies due. • Stirling University Researcher has commenced the qualitative research, interviews being held with key NHS Fife staff involved in	

		Action
	the project. • Regular meetings are being held with Researcher from Stirling University. • Urology MDT survey issued to all MDT participants and initial analysis of results undertaken. Short life working group being set up to determine necessary actions. • Project Manager attended NHS Fife Prostate Improvement Pathway monthly group and provided a project update. • Patient Reported Outcome Measures (PROMS) continue to be recorded by Patient Navigators (PN); PROMS data feeds into a national quality indicator. • PN have developed a patient survey database for recording surveys issued at completion of the patient pathway in the RADC: prostate. • Dashboard has been designed by the cancer audit team to monitor data collected by the project. • Project Manager has completed Datix risk register training. MM to provide a paper at the next meeting regarding the 100 patients. <u>*Single Point of Contact Evaluation*</u> The Hub was developed to support colorectal and urology patients referred USC through their cancer journey until cancer was excluded or diagnosed with secondary benefits of reducing the administrative burden on the CNSs and a point of contact for GPs. KN advised they evaluated the first 6 months (Sept 22 to Feb 23) which shows: • During this time there were 2,789 calls. • The majority of calls were made by patients; however, 15% were made by family members or carers. • Incoming calls to the service increased by 28%. • 90% of calls were resolved by SPOCH with just under 7% being signposted elsewhere. • Patient calls to CNSs reduced as the SPOCH embedded. • They saw an overall 27% reduction in USC (1st OPA) DNAs. • CWT performance was not influenced by introduction of SPOCH. This may not be an appropriate measure as challenges are attributed to operational services who have seen a significant increase in referrals as well as a 24% increase in diagnoses, compared to the last quarter of 2019; complexity of patient pathways is also a factor. • There was an excellent response rate of 26% from the patient evaluation questionnaires with an overall satisfaction score of the SPOCH of 4.33 out of 5. • The staff evaluation questionnaire did not yield a good response with only 17 replies and a low satisfaction rating. • There have been additional processes introduced since the launch	**MM**

		Action
	of the service throughout 2024 such as integration with the RCDS, management of the qFIT negative pathway, supporting initiation the pathway for suspected lung cancers, integration of the SPOCH and the Central Referral Unit and introduction of Queuebuster. • They have identified next steps which they will deliver throughout 2024. • Further evaluation of SPOCH will be undertaken to ensure information is up to date. • Based on the results from the staff questionnaire – Promotion of SPOCH is required. – To look at processes to provide timely results for non-cancer results. – Continued staff training. – Explore if SPOCH support other cancer services.	
6.	**FUNDING**	
6.1	**Funding Governance Process Update**	
	The funding governance process previously agreed shows clear process for the management of funding requests. KN noted the process has been updated to reflect the process required where RIK sponsorship is required. The updated process was circulated to CLT for comment and queries were raised around the function of CLT in relation to funding requests. KN asked if the group can please, support the update of the process to include RIK, where sponsorship is required, and discuss and agree the role/function of the CLT in the funding process The group were in support of the updated process to include RIK. CM advised in terms of the role of the CLT; that group does have a role as clinical experts but it goes alongside the operational understanding of where pressures are so the 2 things have to work together. RM advised that for the CLT meetings they are planning on having more in depth conversations with each of the services and to understand what the constraints that they are facing are. They will then have a better informed idea of where the challenges are and where funding can be catalytic. CD advised from that they need to think about how they join that with the Acute Services Cancer Delivery Group as all of that information, pressures and operational prioritisation is discussed at that group. CD advised she is happy to take this conversation offline to discuss how the 2 groups will work together to make this happen.	**CD**
6.2	**Cancer Funding Update**	
	This was presented to the group for awareness. The SBAR highlights the current funding that has been allocated to NHS Fife during 2023-24.	

		Action
	KN noted CWT funding is expected to be allocated recurringly from 2024-25 and we have been advised it will be included with the general planned care Fife allocation and not as a separate pot as per usual. Over the years recurring funding has been committed against this totalling £279,182. Further recurring funding was given for AO/SACT in addition to the previous year. To date this has supported 2.0 ANPs, Uplift of B6 to B7 Acute Oncology ANP and a SACT Scheduler. Through vacancy SPOCH and CRU have integrated to ensure business continuity. RCDS funding and been extended to September 2024 with funding allocated in this financial year with an agreement that this will be carried forward into the next financial year. Funding for DCE Optimal Lung Cancer and Head and Neck Cancer pathway will cease in March 24. KN noted good work has been done to date and this will be impacted once the funding is finished. For example; • Reduced Waits to CT and expedited CT reporting turnaround times for suspected lung cancer. • Administrative support for both SPOCH and Radiology supporting initiation of the lung cancer pathway. • Same day vetting and reduced waits to 1st OPA for suspected lung cancer. • Reduced waits for staging CT/MRI and expedited reporting for the optimal head and neck cancer pathway. The project manager funding which currently supports the cancer framework will also cease in February 24.	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q3 2023**	
	A SBAR on the cancer waiting times Q3 2023 was sent around the group. CD advised in regard to 62 day performance for the last quarter, in NHS Fife **74.9%** of patients started treatment within the 62-day standard (previous quarter **78.8%**). SCAN **78.9%** and NHS Scotland **72%**. CD advised in regard to 31 day performance for the last quarter, in NHS Fife **92.6%** (**96.6**% previous quarter) of patients met the 31-day standard. SCAN **93.5%** and NHS Scotland **94.9%.** The issues identified were; staffing, facilities, and pathways.	
7.2	**Quality Performance Indicators**	

		Action
7.2.1	**Gynaecology 2020-21/2021-22**	
	VR went through the papers that were shared with the group. ***2020/21*** Case Ascertainment FOR NHS Fife was 157.1% (Cervical), 92.3% (Endometrial),103.4% (Ovarian). Cervical Cancer 2020-2021 NHS Fife met 6 of the 8 QPIs for Cervical cancer. **QPIs not met:** • **QPI1: Radiological staging: Patients who have an MRI of the pelvis performed prior to definitive treatment,** (1 case). In this case it was not possible to accurately stage the cancer - early disease, MRI not required. • **Clinical Trials***:* 0% uptake. No Fife patients were consented for clinical trial. The target was met in SCAN. Endometrial Cancer 2020-2021 NHS Fife met 6 of the 8 QPIs for Endometrial cancer. **QPIs not met:** • **QPI6: Chemotherapy / Hormone Therapy,** (2 cases). Two stage IV patients did not have SACT; 1 patient consented to chemotherapy but deteriorated and was no longer fit and 1 patient's performance status and co-morbidities precluded chemotherapy. • **Clinical Trial QPI:** 0% uptake. No Fife patients were consented for clinical trial. SCAN comment - The target is not met in SCAN, but more clinical trials for endometrial cancer is now open which led to improved performance. Ovarian Cancer 2020-2021 NHS Fife met 8 out of the 12 QPIs for Ovarian cancer (including sub QPIs). **QPIs not met:** • **QPI3: Treatment planned and reviewed at a regional multi-disciplinary team meeting:** (4 cases). 2 patients were discussed	

		Action
	at MDM post operatively, 1 had emergency surgery and 1 patient was an emergency admission and had elective surgery during admission. 1 case was incidental finding of borderline ovarian cancer, for surgical follow up as per MDM. Pathology later reviewed as Grade 1 and patient was re-discussed at MDM. 1 patient was admitted but deteriorated rapidly, for BSC and discussed at MDM retrospectively • **QPI9**: **First-line Chemotherapy:** (7 cases). 4 patients were treated with best supportive care, 3 had co-morbidities and 1 patient was admitted but deteriorated rapidly. 1 patient died before treatment. 1 patient was initially thought to have a borderline tumour, but review of pathology confirmed grade 1; no chemotherapy was given due to low grade disease. For 1 patient, chemotherapy was not recommended due to high risk of complications. • **QPI10 (i): Surgery for advanced disease** All surgery (primary or delayed). (10 cases) 5 patients received neo-adjuvant chemo, 2 patients were inoperable as a result of disease progression and poor response to chemotherapy, 1 patient developed chemo induced neuropathy after first cycle and co-morbidities precluded surgery; 1 patient's combination of fitness and extent of disease precluded cytoreductive surgery; 1 patient with persistent pleural effusion declined surgery due to fitness for anaesthetic. 3 patients were treated with BSC, 1 patient had extensive disease, 1 patient had disseminated disease with significant co-morbidities and 1 patient deteriorated rapidly following admission. 2 patients were treated with hormones, 1 patient's co-morbidities precluded surgery and 1 patient had advanced disease and declined chemo. • **QPI11: Genetic testing in non-mucinous epithelial ovarian cancer** (7 cases). 4 patients did not have a tissue diagnosis, were radiological diagnoses and treated with best supportive care due to co-morbidities. 1 patient was a low grade tumour on surgical follow up. 1 patient wanted some thinking time, but was unable to attend follow up appointment and died shortly after. 1 patient died before treatment. Fife Action identified for QPI3: Triaging of patients in Fife and referral to MDM needs to be reviewed Actions for the whole SCAN network were identified for the following QPIs: • For QPI9: All patients have been reviewed. SCAN results may reflect our longer living population with increased risk of co-morbidities. All were treated appropriately and no action is	

		Action
	identified. • For QPI10 (i): Patients were all treated appropriately and no action was identified. In SCAN, 82.5% of patient diagnosed with FIGO Stage II or higher ovarian cancer have had treatment either with surgery and/or chemotherapy. • For QPI 11: Patients with no tissue diagnosis are not referred for genetic testing, because they are not accepted by the genetic testing service. Protocol for patients with no histology should be investigated. Numbers of patients with no tissue diagnosis are small so the feasibility of testing should be investigated if a blood test is all that is required. ***2021/22*** Case ascertainment for NHS Fife was 157.1% (cervical) 115.1% (endometrial) and 60% (ovarian). Cervical Cancer NHS Fife met 7 of the QPIs for Cervical cancer. Endometrial Cancer NHS Fife met 5 of the 5 QPIs for Endometrial Cancer. **QPIs Not Met:** • **QPI3:** The target was not met showing a shortfall of 0.8% (9 cases). 4 patients were not fit for surgery due to co-morbidities. 2 patients died before treatment: 1 patient suffered from claustrophobia and died prior to staging imaging, MDM discussion and treatment. 1 patient had advanced disease and died before re-discussion at MDM. 1 patient is not treated at time of reporting, surgery not possible. • **QPI6:** The target was not met showing a shortfall of 8.3% (1 case). This patient with synchronous cervical and endometrial cancer, commenced palliative XRT but developed rapidly progressive disease and died. Cervical Cancer NHS Fife met 7 of the 10 QPIs for Ovarian Cancer. **QPIs Not Met:** • **QPI3:** The target was not met showing a shortfall of 1.2% (1 case). 1 patient was referred to Rapid Cancer Diagnostic Service and	

		Action
	admitted, but deteriorated rapidly and was for BSC, discussed at MDM retrospectively. • **QPI9:** The target was not met showing a shortfall of 13.1% (3 cases). In 1 case following referral to Rapid Cancer Diagnostic Service and subsequent imaging, patient was admitted but deteriorated and transition was made to BSC. 1 patient with advanced disease was for NACT but due to worsening SOB and PE deteriorated quickly and died. 1 patient was for NACT subject to fitness and GFR as per MDM. PS3 but wanted to attempt chemo, however due to frailty and deterioration in kidney function and anaemia it was felt not safe; patient became increasingly frail and not fit for treatment, treated with best supportive care. • **QPI11:** The target was not met showing a shortfall of 16.7% (4 cases). 2 patients did not meet eligibility criteria for testing as low grade endometrioid cancers. 1 patient did not have a tissue diagnosis and died before further investigations undertaken therefore did not undergo testing. 1 patient with a tissue diagnosis of high grade serous carcinoma deteriorated quickly and died therefore not seen in Oncology. There was one SCAN wide action identified for NHS Fife: • Endometrial QPI3 - Full staging to be recorded at MDM.	
7.2.2	**Head and Neck 2020-21/2021-22**	
	JY went through the papers that were shared with the group. ***2020/21*** Case ascertainment for NHS Fife is **89.6%**. In NHS Fife 60 patients (55 previous cohort) were diagnosed with Head & Neck cancer. NHS Fife met **10** of the 16 QPIs (including sub QPIs) for Head & Neck cancer. **QPIs Not Met:** • **QPI 5: Oral and Dental Rehabilitation Plan Specification (i)** Target = 95%. The target was not met showing a shortfall of 7.5% (5 cases). Of these 5 patients, for 4 it was not recorded if pre-treatment dental assessment was required or not, and 1 patient the only treatment was diagnostic excision biopsy, therefore this patient was discussed at MDT after treatment. • **QPI 5: Oral and Dental Rehabilitation Plan Specification (ii)**	

		Action
	Target = 95%. The target was not met showing a shortfall of 7.5% (4 cases). For these 4 patients, 2 were not referred to the dental team, 1 patient did not attend the appointment, and 1 patient was assessed after treatment had started, but prior to adjuvant chemoradiation. • **QPI 6: Nutritional Screening** Target = 95%. The target was not met showing a shortfall of 13.3% (11 cases). For these 11 patients, 9 were not screened prior to treatment with best supportive care (7 were discussed in the Lothian MDT and 2 were discussed in Tayside), 2 patients were not screened prior to wide local excision. • **QPI 7: Specialist Speech and Language Therapist Access** Target = 90%. The target was not met showing a shortfall of 9.4% (6 cases). All 6 patients were not referred to SLT or assessed by SLT prior to treatment. Additionally, 5 patients did not have the intent of their surgical treatment recorded, so did not enter the Denominator as curative intent could not be established, of these patients 2 were seen by SLT prior to surgery. • **QPI 10: Post Operative Chemoradiotherapy** Target = 55% The target was not met showing a shortfall of 21.7% (2 cases). 1 patient was treated with adjuvant radiotherapy only (clinical decision not to offer chemotherapy) and was treated in Tayside. 1 patient didn't require adjuvant therapy as per MDT decision. • **QPI 12: Clinical Trials** Target = 15% The target was not met showing a shortfall of 0.1%. There were no actions identified for NHS Fife. ***2021/22*** Case ascertainment for NHS Fife is **90.1%**. In NHS Fife 64 patients (60 previous cohort) were diagnosed with Head & Neck cancer. NHS Fife met **12** of the **21** QPIs (including sub QPIs) for Head & Neck cancer. There were **3** QPIs with no patients applicable for analysis. **QPIs Not Met:** • **QPI 4: Smoking Cessation** Target = 95%. The target was not met showing a shortfall of 20.0% (4 cases). For these 4 patients data was not recorded. They were discussed in the NOSCAN (Tayside) MDT and smoking cessation was not documented. • **QPI 5: Oral and Dental Rehabilitation Plan Specification (i)**	

		Action
	Target = 95%. The target was not met showing a shortfall of 4.1% (4 cases). For these 4 patients the decision for requiring assessment was not recorded. All patients were discussed at the Lothian MDT. A further 1 patient was not in the denominator due to treatment intent not being recorded (not recorded for the denominator). • **QPI 6(i): Nutritional Screening** Target = 95%. The target was not met showing a shortfall of 23.1% (18 cases). For 13 patients MUST screening was not performed. 12 of these patients were discussed in NOSCAN (Tayside) MDT and all 12 had dietetic input in Fife, 1 patient in Lothian MDT (patient was under paediatric team and confirmed as having dietetic input from both Lothian and Fife dietitians). For a further 5 patients screening was not performed (3 of these patients were discussed in NOSCAN (Tayside) MDT, 1 patient declined screening and died shortly after diagnosis, and 1 patient did not attend the MDT clinic). • **QPI 6(ii): Nutritional Screening** Target = 90%. The target was not met showing a shortfall of 23.3% (2 cases). For these 2 patients assessment did not occur but dietetic input was provided or offered to both patients. Additionally, for 13 patients a MUST score was not recorded (12 of these patients were discussed in NOSCAN (Tayside) MDT and all had dietetic input in Fife. • **QPI 14: Time from Surgery to Adjuvant Radiotherapy/ Chemotherapy** Target 50%. The target was not met showing a shortfall of 35.7% (6 cases). These 6 patients had surgery in NOSCAN (Tayside). 3 patients had complications following initial surgery, 2 patients did not have a documented reason for delay, and 1 patient did not have their pathology available at the first oncology appointment. • **QPI 15: PD-L1 Combined Proportion Score (CPS) for Decision Making** Target 75%. The target was not met showing a shortfall of 75.0% (1 case). For this 1 patient PD-L1 was not requested at the Lothian MD.	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised there has been no change since the last meeting. There have been a couple of additional patients recruited into the FOXTROT (colon cancer) clinical trial. There are currently 20 active clinical research studies in place.	
9.	**REALISTIC MEDICINE**	
9.1	**Realistic Medicine Update**	
	This will be carried forward to the next meeting.	

		Action
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Managers' Forum (27/10/2023)**	
	This was noted by the group.	
10.2	**Acute Cancer Services Delivery Group (08/11/2023 & 06/12/2023)**	
	This was noted by the group.	
10.3	**Cancer Leadership Team (24/10/2023)**	
	This was noted by the group.	
11.	**ITEMS TO NOTE**	
	No items to note	
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	No issues to be escalated to EDG or the Clinical Governance Committee.	
13.	**ANY OTHER BUSINESS**	
	No any other business.	
14.	**Date of Next Meeting**	
	The next meeting will be on Thursday 21 March 2024, 14:00-16:00 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP (Meeting on 13 February 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date: 20/02/2024
Enquiries to: April Robertson
Telephone Ext: Microsoft Teams

UNCONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 13th FEBRUARY 2023 via MICROSOFT TEAMS

Attendees

Lynn Barker (LB)	Director of Nursing, HSCP
Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Gemma Couser (GC)	Associate Director of Quality & Clinical Governance
Pauline Cumming (PC)	Risk Manager
Fiona Forrest (FF)	Deputy Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Robyn Gunn (RG)	Head of Laboratory Services
Aileen Lawrie (AL)	Director of Midwifery
Dr Iain MacLeod (IM)	Deputy Medical Director
Dr Chris McKenna (CMcK) (Chair)	Medical Director
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Dr Shirley-Anne Savage (SAS)	Associate Director for Risk & Professional Standards
Amanda Wong (AW)	Director of Allied Health Professions

In Attendance

Lee Cowie (LC)	Clinical Services Manager, Child/Adolescent Mental Health, HSCP
Lizzy Gray (LG)	Patient Experience Team Lead (for Siobhan Mcilroy)
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)

Apologies

Dr Sue Blair (SB)	Consultant in Occupational Medicine
Benjamin Hannan (BH)	Executive Director of Pharmacy and Medicines
Janette Keenan (JK)	Executive Director of Nursing
Dr Sally McCormack (SMcC)	Associate Medical Director for Emergency & Planned Care
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr John Morrice (JM)	Associate Medical Director of Women & Children
Nicola Robertson (NR)	Director of Nursing, Corporate
Gavin Simpson (GS)	Consultant Anaesthetics
Prof Morwenna Wood (MW)	Director of Medical Education

	Items	Action
1	**Apologies for Absence (CMcK)**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 12th December 2023 (CMcK)**	
	The Group confirmed that the note from the meeting held on the 12th of December 2023 was an accurate record.	
3	**Matters Arising/Action List (CMcK)**	
	3.1 - SBAR on Escalation of increased incidences reported for unavailability of Urgent Care Mental Health Assessment Team (UCAT) Compliance **(LB)**	

	LC spoke to the above SBAR; this was to provide assurance that work was underway within the Mental Health Urgent Care Assessment Team (UCAT) to mitigate the risks and service delivery challenges outlined previously by the corporate adverse events team via NHS Fife CGOG. The issues highlighted by the Adverse Events team related to an increased number of Datix submissions from Urgent Care & Assessment Fife (UCSF) between August 2023 and December 2023. During the period June 2022 to June 2023 there was as significant reduction in workforce availability due to both long term and short term sickness absence. Additionally, in the context of national workforce pressures, recruitment to vacant posts was unable to keep pace with attrition over time. In addition to the actions taken by the service to minimise the impact of reduced workforce (additional hours, bank provision, staffing resource reallocation) agreement was reached by Heads of Service that Unscheduled Care Services Fife (UCSF) would use the Datix system to record occasions when UCAT was unable to provide service due to lack of staffing. The intention of this was to quantify the service impact caused by staffing depletion in UCAT. Implementation of this generated a large volume of Datix reports August to December 2023. He added there were 2 key elements with regard to developments to improve the service; • To assure members of the ongoing work to build and sustain optimal service capacity and delivery within the mental health Urgent Care & Assessment Team (UCAT). • To provide assurance on the programme of improvement, delivered through the MHUUC Project team, to benchmark the current model of care and develop the service in order to best respond to the needs of the Fife population and within the resources available. CMcK asked around the conscious decision to record these incidents on Datix, that it would be useful when this plan was made that the let the Adverse Events team know. They can then predict, giving more knowledge and understanding when the data is collected. He added this had been a very useful exercise resulting in a very helpful detailed paper. It would be beneficial for a version of this paper to go to Clinical Governance Committee (CGC). GC noted that this report primarily focused on nursing staff and wondered about the pressures on medical staff as a result. This provoked a conversation in the Group, HH agreed that going forward it would be beneficial to capture the medical staffing issues, as the paper does report that medical staff are called upon when there are nursing staff issues.	
4	**GOVERNANCE**	
4.1	Draft Annual Statement of Assurance for Clinical Governance Oversight Group **(SAS)**	
	SAS shared the paper with the group and asked for any comments by 16th February before submitting this comprehensive paper to CGC. She also added that there had been a questionnaire sent to the group membership inviting them to comment on the effectiveness of CGOG. One of the main things in the feedback was the quantity of	

	items on the agenda. An attempt has been made to address this and keep the meeting to time by adding timings to the agenda and seeking comments on papers prior to the meeting.	
4.2	SBAR NHS Fife Annual Organisational Duty of Candour Annual Report 2022/2023 **(SAS)**	
	There were 33 adverse events requiring DoC with the most common outcome, for 24 patients, being an increase in a person's treatment. Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified including notifying the person and providing details of the incident, provision of an apology, reviewing all cases and offering support and assistance. There was Improvement since last year on providing the patient with a written apology. There was one area identified for improvement and that was arranging a meeting following an offer to meet. This was noted by the Group and no comments made.	
4.2.1	NHS Fife Annual Organisational Duty of Candour Annual Report 2022/2023 **(SAS)**	
	This was noted by the Group.	
4.3	Fife Partnership Review of Children and Young People's Deaths - Annual Report **(CF)**	
	CF informed the group that this report would be presented at the August meeting. The decision had been taken change to fiscal year reporting in line with other board reports and the National Hub.	
4.4	NHS Fife Health & Social Care Partnership Clinical Governance Assurance Update SBAR **(HH/LB)**	
	LB told the group this report relates to: Fife HSCP Quality Matters Assurance Group Clinical Quality (QMAG) meeting on 1st December and an overview of the 3 Quality Matters Assurance Safety Huddles (QMASH) held between 6th October and 1st December. LB highlighted from the report; • **Internal Audit Service Report (Assurance)** The SBAR paper outlined the level of assurance achieved following the Internal Audit on Risks 10 and 11 as "Reasonable Assurance". *"There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope form improvement were identified which may put at risk the achievement of objectives in the area audit."* She informed the Group that an action plan has been submitted and these recommendations would be completed by 31st March 2024. • **Child Protection Quarterly Report Update (Assurance)**	

	The Head of Service (HoS) presented a high level overview of the comprehensive report, providing a summarised update on the activities overseen by the Child Protection Health Steering Group, focusing on child protection initiatives and the forthcoming implementation of refreshed child protection guidance by the end of April next year 2024. The Head of Nursing highlighted changes in the national guidance for child protection in Scotland and outlined the significant project plan which will be supported by the Lead Nurse for Child Protection to implement with health visiting as the initial pilot area. The goal is to complete the ambitious implementation by April 2024, recognising the challenges of a small team. CMcK appreciated that this was a very thorough paper by CG. He also noted that within the report there was an "action plan" with regard to "attractive stock" at Glenrothes Hospital. FF responded that there was an internal action plan within pharmacy concerning the processes around these medicines and an organisational action plan currently in draft which will come through the appropriate governance routes including CGOG to provide assurance with regard to these medicines.	
4.4.1	Appendix 1 Child Protection Quarterly Report **(HH/LB)**	
	LB spoke to the group informing them that the purpose of this report was to provide the Quality Matters Assurance Group with an update and assurance around the activities which have taken place in relation to child protection in the period April to September 2023. The Child Protection Health Steering Group meets every two months and therefore has had two meetings in the reporting period. The agenda for the group covered:- • Public protection accountability and assurance framework; • Notification of child concern data; • SBAR on the implementation of the revised guidance; • Draft Child Protection annual report; • SBAR enquiries into misconduct which considered the learning from the enquiries undertaken by two local authorities into historical abuse; • Children & Young People death review annual report. She added she hoped colleagues would take assurance from this extensive update.	
4.5	NHS Fife Acute Services Division Clinical Governance Assurance Update (**IM/NB)**	
	IM spoke to the assurance update: There is ongoing work to streamline the Acute Services CGC committee to make it as relevant as possible. The vision is for Directorates to hold as much governance as possible at a local level. The Chairs of the committee have committed to spending time with each of the three Directorates to try and improve the work of clinical governance within the Division. IM highlighted from the paper that; **Emergency Care Directorate**	

	• Significant increase in critical incident reporting in September and October. In October there were 39 major harms – highest number. • Concern raised about number of incidents needing investigated and difficulty getting engagement in some areas to do the work due to other pressures. This is a vicious cycle and although this is most evident in ECD, there was support from the other Directorates. • Significant fall in % of patients being admitted to hospital within 4 hours (49.3% in 2022 vs 88% in 2021). • Slight fall in completion of Comprehensive Geriatric assessment within 3 days. **Planned Care Directorate** • Scottish Hip Fracture Audit showed rising incidence of hip fractures. • Scottish Arthroplasty project showed a rise in number of procedures in hip and knee replacements bringing them almost back to pre pandemic level with the independent sector being the largest provider for the first time. • Significant increase in number of incidents reported. 297 reports, 64 of which involved harm. Significant impact of falls and tissue viability incidents within PCD come from NTC. This is new for the directorate. This is mostly due to frailty and a planned Deep Dive is being completed to see if there are any common themes. **Women & Childrens' Directorate** • MBRRACE (Mothers & Babies: Reducing Risk through Audits and Confidential Enquiries) follow up. Most of the actions from the report have been implemented. There has been an improvement in the Neonatal mortality and cooling rates in 2022. This report was provided for assurance. • There have been 4 babies cooled in 2023, therefore a cluster review has been commissioned to examine any commonality. He concluded this update was a work in progress and would be presented differently at future meetings with assistance from GC and EM. GC felt it would be a positive step forward for the group to take a view on improvement actions, changing their focus to proactive instead of reflecting. She added she was eager to attend the Acute Services Division Clinical Governance Group and also the QMAG to see how she could push some of the proactive, quality planning forward.	
4.6	NHS Fife Acute Services Division Health Improvement Scotland Inspection Update August 2023 (**IM/NB)**	
	NB shared; During the inspection the inspection team used the following methodology:	

- Inspected the ward and hospital environment.
- Observed staff practice and interactions with patients, such as during patient mealtimes.
- Spoke with patients, visitors, and ward staff
- Accessed patients' health records, monitoring reports, policies and procedures
- Discussion sessions with key members of staff
- Unannounced return visit on Monday 14 August 2023 to follow-up on concerns raised.

This inspection resulted in four areas of good practice, two recommendations and nine requirements. The inspectors noted that the staff they spoke to felt supported and listened to and that staff were responsive to patients' needs. Serious concerns were raised about the condition of the healthcare built environment, Phase 1 which was noted to be in very poor condition. Concern was also raised about the oversight, communication, and escalation processes in relation to the condition of the environment.

The areas of good practice included:

- Hospital safety briefings were well run, structured, inclusive and informative.
- Adult with incapacity care plans were clear, detailed and completed appropriately.
- Safety huddles were inclusive and gave a whole site view.
- Staff take time to reassure patients and carers.

The two recommendations related to:

- NHS Fife should consider including healthcare built environment risks as an item on the Senior Charge Nurse 1:1 discussion template.
- NHS Fife should consider patient dependency and complexity, staff skill mix and professional judgement when declaring 'safe to start'

A comprehensive action plan has been agreed by NHS Fife, which was accepted by the HIS Inspection team. A tracker has been developed to support oversight of progress against the agreed actions. This is within the attached update.

Oversight arrangements to ensure timely progress and to support governance assurance via Acute Services Division (ASD) governance structures into NHS Fife's Corporate Governance was agreed. Acute Senior Leadership Team (SLT) acts as the core oversight group with IPCT and Estates colleagues invited as temporary substantive members monthly to jointly oversee progress. SLT will then share regular governance reports to ASD Clinical Governance Group and the NHS Fife Clinical Governance Oversight Group.

NB informed the group this visit had resulted in the immediate decanting of Ward 5, Ear Nose & Throat in Phase 1 to Ward 10 in Phase 2. There has been a major upgrade to ward 5 and this work is on track and should be completed toward the end of March 2024.

NB added one of the actions was the Welch Allyn project, and moving forward with the 'observations on time' solution, there has been some discussion at SLT around the length of time this has taken, this has been extremely challenging and the trial is still not in place.

	CMcK offered his support with regard to the Welch Allyn project. IM added this had been identified as fundamental to patient care and was supported through the 'Deteriorating Patient' work. This had originally taken some time to pass through finance and was now being held up from a Digital & Information point of view.	
4.7	NHS Fife Clinical Policy & Procedure Update December 2023 **(EM)**	
	EM advised at the 18th December 2023 meeting, the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that; There were **two** policies made obsolete; • DC-U-01 - NHS Fife Wide Staff Dress Code and Uniform Policy – moved to HR Policies and Procedures • C-01 – NHS Fife Wide Policy for Child Protection - Unborn Child – superseded by a new fife wide procedure There are **two** Fife wide procedures past their review date; **Fife Wide Procedure** • FWP-HP-01 - NHS Fife Wide Adult In-patient Hydration Procedure (08/10/2023) Review is currently being undertaken. The aim is to have this procedure reviewed and back to the group as soon as possible • FWP-BBMHB-01 Fife Wide Procedure for Babies Born to Mothers with Hepatitis B Infection and/or Babies Born into a household where a member (other than the mother) is known to be infected with Hepatitis B (01/04/2023) Comments have been received from Dr Helen Botherton for reviewer to update procedure and bring back to the group. The group were given assurance that they have a 99% compliance rate for all clinical policies and procedures for NHS Fife.	
4.8	NHS Fife Activity Tracker **(EM)**	
	EM shared the activity tracker with the group, there was nothing new to note.	
4.9	NHS Fife Scottish Health Technology Group Update **(EM)**	
	EM advised the group; The Scottish Health Technologies Group (SHTG) is a national health technology assessment (HTA) agency which provides advice to NHS Scotland on the use of new and existing health technologies (excluding medicines), which are likely to have significant implications for people's care. NHS Scotland is required to consider the advice produced by SHTG. NHS boards are required to consider advice from SHTG. It is not mandatory to follow the advice, but they should have processes in place to receive, communicate and consider the advice produced.	

	In April 2023, a process was designed in order to ensure that NHS Fife meets the requirement for NHS Boards to consider the advice produced by SHTG and that the appropriate governance is in place. The process requires that each report is reviewed and documented through an audit trail. Since the start of the process:- • 24 Reports have been through the process – (18 Assessments and 6 Recommendations) • 18 Reviews have been completed – (13 Assessments and 5 Recommendations) • 6 Reviews are currently outstanding – 2 are in the process of being escalated. EM concluded in summary that if SHTG were to visit, we have an audit trail where we can show that our process is working and all recommendations and assessments for clinical colleagues to review and feedback summary report. This gives assurance the processes are working.	
4.10	Review of Draft NHS Fife Clinical Governance Oversight Group Annual Workplan 2024/25 **(GC)**	
	This was noted by the group, GC commented that once it was finalised it would be shared with the membership prior to April's meeting for any comments.	
5	**NHS FIFE CORPORATE RISK**	
5.1	SBAR - NHS Fife Corporate Risk Register - Risks aligned to Clinical Governance Committee **(SAS/PC)**	
	PC shared the following highlights from the SBAR; Further to the last report to this Group, the Director of Public Health confirmed to the CGC on 12 January 2024, that the Covid-19 risk had achieved and surpassed its risk target, and that reviews over a period of time showed the risk had remained stable. A closing Deep Dive review and supporting SBAR set out the management actions in place, and the rationale to support closing the risk on the Corporate Risk Register and managing it as business as usual. The Committee took assurance on the Deep Dive and agreed on the recommendation to close as a Corporate Risk and transfer oversight to the Public Health Assurance Committee. There had been a lot of discussion at CGC around the 'Quality & Safety' risk, The risk review indicated the potential to reduce the risk level from high to moderate. Subsequently it was agreed that the risk level should remain at high pending a review of governance arrangements related to quality, safety and organisational leaning. The Group is advised that it is now possible to confirm the adequacy and effectiveness of our governance arrangements. It is therefore recommended to proceed with the proposed reduction in the current risk level and rating from High 15 to Moderate l2. If agreed, this would bring the risk within its risk appetite of Moderate. With regards to potential Corporate Risks, the Director of Public Health and colleagues are preparing a new risk to be considered for inclusion on the Corporate	

	Risk Register which will address wider threats to the healthcare system such as pandemic preparedness/biological threats . This will be presented to the CGC in May 2024. PC concluded by informing the group that, working with their colleagues within the NHS Fife Risks & Opportunities Group, the process around commissioning deep dives was being refined and triggers were being reviewed going forward. Also, how the content of deep dives could be enhanced, any updates would be brought to CGOG in due course. GC pointed out that organisational learning reference link should be removed from 'Quality & Safety' risk. The Organisation Learning Group (OLG) is currently under review, so it is no longer appropriate to say the OLG is providing assurance in terms of the patient safety outcomes experience. She is happy to take this forward with SAS & PC. CMcK answered that there had been a change in the belief / understanding of the function / role of the OLG, in relation to assuring the CE of quality and safety within the organisation. This is not what the group was intended to do, it was intended to provide an opportunity for a cross pollination of learning from various aspects of our organisation.	GC/SAS/ PC
5.1.1	Appendix 1 - NHS Fife Corporate Risks Aligned to the Clinical Governance Committee as at 2nd February 2024 **(SAS/PC)**	
	This was noted by the Group.	
5.1.2	Appendix 2 - Deep Dive Review on Optimal Clinical Outcomes **(CMcK/SAS)**	
	SAS shared with the group that this was a second deep dive on Optimal Clinical Outcomes; this took a more in-depth account of the cost of living crisis, where the previous deep dive had concentrated more on the Covid-19 Pandemic. CMcK noted that he found this additional detail helpful and if anyone wished to comment on this before it goes to Executive Directors Group (EDG) they should do so now.	
5.1.3	Appendix 3 - Committee Assurance Principles	
	This was noted by the Group.	
5.1.4	Appendix 4 - NHS Fife Risk Assessment Matrix	
	This was noted by the Group.	
6	**ADVERSE EVENTS UPDATE**	
6.1	NHS Fife Adverse Events KPI's **(CF)**	
	CF advised that there were still significant overdue SAER's and LAER's. On a positive note in December the action rate of 'closure on time' was 50%, hopefully this good work could continue and raise the rate further.	
6.2	NHS Fife Adverse Events Themes & Trends Report **(CF)**	

	CF shared the Themes and Trends Report with the Group pointing out; Overall 16,981 incidents reported in 2023, an increase on the 16, 653 reported in 2022. The top 5 reported incident categories remains consistent across the year, with unwanted behaviours, violence and aggression accounting for 21% of all reported incidents. There has been an increase in unwanted behaviours, violence and aggression incidents which equate to 50% of the overall increase in reports in comparison to 2022 (3266 reported in 2022, 3429 reported in 2023). Further interrogation of the data shows the increase is consistently across the year in the subcategory of physical assault on staff. 4 incidents reported as severity major/extreme in compared to 1 in 2022. As expected, due to patient the group and a good culture of reporting of this incident type; the majority of the incidents are reported in HSCP, in particular mental health and learning disabilities. Physical assaults on staff in mental health have increased by 50% and decreased in learning disabilities by 32%. CF went on to explain that the following is underway in the management of unwanted behaviours, violence and aggression incidents: • Targeted work underway in mental health • Governance route – reported as part of a wider report on health and safety incidents, data prepared by Fife Safety and Wellbeing team and presented at various groups such as the Area Partnership Forum and Health and Safety Sub-Committee. CMcK commented that there are Health & Safety committees in H&SCP, Acute Services Division and a board wide Health & Safety Committee. We must insured that these findings are being aired at these groups and the plans around this are being articulated. LB acknowledged the data presented by CF and confirmed that this was on the agenda of the H&SCP Health & Safety agenda, however, she will take an action to look into / identify the routes that this information goes to and ensure this data is shared and acknowledged. CMcK acknowledged this rise in incidences of violence and aggression and asked this come back to the April meeting to take some assurance around how those incidents are being reported and managed throughout our Governance system. CF also shared with the group that from the clinical governance matrix, there had been 2 trigger list workshops to redefine the structure of reporting and what should be reported as major and extreme events. Both workshops were very well attended across the organisation. CF will bring a paper to April's meeting to describe the outcome of these meetings and propose options on how best to define, report and manage major/extreme events going forward. CMcK recalled that historically NHS Fife had made additions to their matrix, over and above the HIS matrix, he would like this to be "pared back" so it's fully understood what an SAER is and how this can be managed locally. He felt we need something more bespoke where we ask the right questions and there is a consistency in	**LB** **LB** **CF**

	approach. CF concluded that when looking at the trigger list there is currently quite a mixture. As a group there was a consensus that the focus should be the 'outcome' for the patient when applying the national framework. GC added she didn't want the group to lose sight of the 16,000+ events reported annually, 85% of those are minor or no harm and it was good to get enthusiasm from this group for a different approach. CMcK said we should consider how we bring in the Quality Improvement (QI) teams into this work as we have demonstrated really effective contributions from the QI work around 'Deteriorating Patient' and this work was driven from this Group. FF concurred that she welcomed the approach to review and streamline the process and focus around the consistency and the learning. In relation to medication incidents, she felt there had been quite a lot of learning and it was timely for this to be reviewed and consider what to do as an organisation so that any enquiry could have a consistent approach to an incident. CMcK asked the group that going into the new financial year he would like the members to consider a modified, simplified approach that we can begin to use. Around report writing, AL raised the point that particularly within her directorate of Women & Children, the 'look back' aspect of an investigation can be of vital importance and whilst it should still be required to be done, perhaps it could be a summarised within the report without providing the lengthy detail if no issues had been identified. CMcK agreed that for every investigation, a look back at what happened before was required. What had to be looked at was what would be included in a report versus a timeline. Giving people the permission to say, "as per timeline" and summarising the vital elements. This would stop the duplication of work from the timeline into the report.	
6.3	NHS Fife Adverse Events Flashcard **(CF)**	
	This was noted by the group.	
7	**PATIENT EXPERIENCE**	
7.1	NHS Fife Patient Experience Flashcard **(JK/SM)**	
	LG shared the flashcard with the group pointing out that the total number of complaints, concerns and enquiries was 2070, 554 were stage 1 and 336 were stage 2 complaints. It was worth noting the number of concerns (467) and enquiries (713) as these were often unseen work of the Patient Experience Team (PET). The themes of complaints were consistent throughout the year; • Disagreement with treatment / care plan • Co-ordination of clinical care & treatment • Staff attitude • Poor nursing care • Communication She pointed out that although communication was not the top theme it ran consistently through other complaints.	

	LG acknowledged that closure of complaints on time hadn't been within timeframes due to current pressures across all services. She added that the team had done a lot of work to reduce the backlog and there was service improvement work within the department to streamline processes. With regards to 'Care Opinions' – There had been a substantial number of stories received and these were mainly very positive. The compliments received by the PET remained very high and this was good to see. LG highlighted from the PET updates; • Single point of contact with a consistent approach • **EARLY RESOLUTION** o Stage 1 – Services to resolve which is improving o No written response unless last resort o Stage 2 – offering a meeting prior to response o Stage 2 – do we really need to offer a meeting after final response letter. **WORKFORCE TOOL** o Review PET Establishment, awaiting national figures **SAER and Complaint Process** o Looking at the process for Complaints and SAER's o Flow Chart being developed CMcK felt it was very important to recognise all the hard work being undertaken to change our approach to complaints. He thought it would be beneficial for SM or LG to be invited to the consultant inductions. Although JM spoke to the section on 'complaints' at these inductions it would be good for the PET to support this presentation. LG informed the group that she had enlisted the services of Sharon Doherty NHS Fife consultant psychologist) for their team due to the negative content of much of the team's work. AW pointed out that when looking at the flashcard it was positive to see that the patient opinions and the compliments combined, they are triple the number of complaints.	
8	**STRATEGY & PLANNING**	
8.1	NHS Fife Clinical Governance Strategic Framework Annual Delivery Plan 2023/2024 **(GC)**	
	GC informed the group she would bring the annual delivery plan for 2023/2024 to look back on the year as well as a proposed plan for 2024/2025.	
8.2	NEWS2 **(GC)**	
	GC shared that the project group was now established and work was underway with the clinical team to start to look at the specification of NEWS2. She can provide a more informed update at the April meeting. CMcK thought we should consider under the current financial circumstances whether NEWS2 was still required.	

	GC agreed that it was prudent to ask the question again, the components of NEWS2 were now fully implemented into 'Deteriorating Patient'.	
9	**QUALITY/PERFORMANCE**	
10	**LINKED COMMITTEE MINUTES**	
10.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, unconfirmed - 18th December 2023 **(EM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.2	NHS Fife Organ Donation and Tissue Committee – 21st December 2023 **(NR)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.3	NHS Fife Health & Social Care Partnership Quality Matters Assurance Group - 1st December 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.4	NHS Fife Acute Services Division Clinical Governance Committee, unconfirmed - 22nd November 2023 **(IM)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.5	NHS Fife Health & Social Care Partnership Falls Oversight Group - 16th October 2023 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.6	NHS Fife Organisational Learning Group unconfirmed - 24th November 2023 **(NR)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.7	Fife Partnership Reviews of Children & Young People Deaths' Governance Group - 7th December 2023 **(CF)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.8	NHS Fife Point of Care Testing Committee - 6th December 2023 **(EM)**	
	This meeting was cancelled, next meeting date is 6th March 2024.	
10.9	NHS Fife Tissue Viability Working Group - 4th January 2024 **(LB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
10.10	NHS Fife Resuscitation Committee - 6th December 2023 **(JB)**	
	The minutes of the meeting were noted by the group and no escalation is needed.	
11	**ITEMS TO NOTE / INFORMATION**	

11.1	NHS Fife Clinical Governance Oversight Group Workplan 2023 - 2024 **(EM)**	
	There was nothing to highlight from the Workplan.	
11.2	Clinical Governance Oversight Group Assurance Summary 12 December 2023 **(SAS)**	
	This was noted by the Group.	
11.3	Deteriorating Patient December 2023 Highlight Report **(EM)**	
	This was noted by the Group.	
11.4	Deteriorating Patient January 2024 Highlight Report **(EM)**	
	This was noted by the Group.	
11.5	NHS Fife Clinical Effectiveness Register **(EM)**	
	This was noted by the Group.	
12	**ISSUES TO BE ESCALATED**	
	No issues for escalation.	
13	**ANY OTHER BUSINESS**	
	Date of Next Meeting 16th April 2024 10:00 via Microsoft Teams	

AREA DRUG & THERAPEUTICS COMMITTEE (Meeting on 20 December 2023)
No issues were raised for escalation to the Clinical Governance Committee.

Area Drug & Therapeutics Committee

CONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 20 DECEMBER 2023 AT 2.00PM VIA MICROSOFT TEAMS

Present:
Mr Ben Hannan (Chair)
Dr Ian Fairbairn
Ms Claire Fernie
Dr Helen Hellewell
Dr Sally McCormack
Mr Fraser Notman
Ms Olivia Robertson
Ms Andrea Smith
Ms Amanda Wong
Ms Doreen Young

In attendance:
Ryan Headspeath (items 7.2, 7.3, 7.4)
Mr Duncan Wilson (item 12)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the December meeting of the ADTC.

Apologies for absence were noted for Claire Dobson, Dr Iain Gourley, Dr David Griffith, Dr Claudia Grimmer, Dr John Morrice, Rose Robertson, Mr Satheesh Yalamarthi.

2 MINUTES OF PREVIOUS MEETING ON 16 AUGUST 2023

The minutes of the meeting held on 16 August 2023 were accepted as a true record.

3 ACTION POINT LOG

The action list was discussed and actions updated/completed as agreed.

Prescribing in Renal Impairment (DOACS) - Response to MHRA Update
A substantive item to be brought to the February ADTC. **AW**

Melatonin Prescribing - Update
It was noted that there was no update at present. Mr Notman to follow up with Niamh Morrison in the New Year. A sitrep/update to be brought to the February ADTC. **FN/NM**

Progress in NHS Fife against SGHD/CMO(2019)4 National Guidance for Monitoring Lithium

A substantive item to be brought to the February ADTC. **JB**

Return & Destruction Audit
Responsible lead for tracking of actions to be transferred to A Smith. To be brought back to the ADTC in due course. **AS**

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 (ERF) Committee and highlighted key points.

All adult chapters of the ERF have been agreed and approved. Review of the paediatric chapters is continuing, with five paediatric chapters now completed (Cardiovascular, Central Nervous System, Gastrointestinal, Infection and Respiratory). The next paediatric chapters scheduled for review are Endocrine and Skin and chapter expert working groups have been established to take these forward.

Challenges were highlighted around communicating the application process to ensure consistency of approach across the region. The business as usual process is protracted and Mr Notman is working with the other East Region Formulary Pharmacists to improve this.

A discussion followed about the impact of the move to the ERF in relation to monitoring Formulary compliance and prescribing costs. Mr Notman and Mr Hannan to discuss analysis of the data for the ERF chapters reviewed to date and an interim update to be brought to the February ADTC. **FN**

Dr McCormack highlighted the East Region Formulary app and the need for wider communication around use of the app within NHS Fife. Mr Notman to discuss with the Communications team. **FN**

The ADTC noted the update from the ERF Committee and the minutes from the meeting on 11 October 2023.

6.2 MSDTC

Dr McCormack introduced the update report on behalf of the MSDTC and highlighted key points.

Business as usual is continuing and the group is functioning well. Changes in membership were noted (Cardiology and Respiratory Pharmacist, Head of Nursing Corporate/Acute, Consultant Psychiatrist and a change in administrative support).

It was noted that there have been recent submissions relating to non-Formulary approved medicines and agreed that a reminder about the normal governance routes for submissions be included as part of wider discussions between Pharmacy and the Communications team. **FN**

The ADTC noted the update on behalf of the MSDTC and the minutes from the meeting on 18 October 2023.

6.3 Antimicrobial Management Team

Mr Hannan introduced the update report on behalf of the Antimicrobial Management Team and highlighted key points.

The ADTC noted the current progress and workplan for the next six months.

The ADTC noted the challenges as a result of staffing/recruitment issues. A meeting is scheduled for late December to discuss antimicrobial responsibilities. An antimicrobial pharmacist has been recruited and is due to take up post in the New Year.

The ADTC noted the update report on behalf of the Antimicrobial Management Team.

6.4 Fife Prescribing Forum

Mr Notman introduced the update report on behalf of the Fife Prescribing Forum and highlighted key points.

A new standard operating procedure which includes an exemplar report has been produced as a guide to assist Specialist Pharmacists with the production of their update reports to the Prescribing Forum.

Meeting dates and specialty invites for 2024 have been arranged. There is good engagement with specialties and excellent reports produced. The importance of the intelligence gathered at the Fife Prescribing Forum in helping to inform the medicines optimisation agenda going forward was noted.

The ADTC noted the update report on behalf of the Fife Prescribing Forum.

6.5 PGD Group

Mr Notman introduced the update report on behalf of the PGD Group and highlighted key points.

The ADTC noted that work with the Hospital at Home team has progressed and a number of PGDs no longer required for Hospital at Home have been

retired. It was noted that Mr Hannan has requested that Anne Wilson, Lead Clinical Pharmacist Community Health, produce a more detailed review of Hospital at Home PGDs still in use for the ADTC meeting in April 2024.

A discussion followed about the risk management tool. It was noted that the relevant risk score is based on the complexity and nature of the individual PGD and assists with the PGD review prioritisation process.

The ADTC noted the update report on behalf of the PGD Group.

6.6 NHS Fife Medicines Safety and Policy Group Terms of Reference

Ms Smith introduced the Terms of Reference for the NHS Fife Medicines Safety and Policy Group and briefed the ADTC on the background to the establishment of the group.

The Medicines Safety and Policy Group has evolved from the Safe and Secure Use of Medicines Group and the Terms of Reference has been revised accordingly. The first meeting of the group was held in early December and there was good engagement and attendance. Subsequent meetings will be held 6-weekly.

Paragraph 2.10 “Monitor major and extreme incidents relating to medicines and disseminate/share knowledge gained from all incidents to ensure staff supported and lessons are learned” was highlighted and clarity sought around the mechanism for follow up to ensure that any required changes have been implemented. It was noted that action plans are produced and brought back through the Quality Medicines Advisory Group for assurance.

The ADTC approved the Terms of Reference for the NHS Fife Medicines Safety and Policy Group.

7 SBARs/Updates

7.1 High Risk Pain Medicines Guidance

Mr Hannan highlighted the High Risk Pain Medicines Guidance. This item was previously circulated virtually to the ADTC membership for comments and approval and the finalised documentation has been brought to the ADTC for homologation of the decision.

The ADTC approved the High Risk Pain Medicines Guidance and associated documentation.

7.2 Shared Care Agreement for Roxadustat

Mr Headspeath introduced the Shared Care Agreement for Roxadustat and briefed the ADTC on the background to this.

The information in the Shared Care Agreement for Roxadustat is largely similar to the Shared Care Agreement for Erythropoietin stimulating agents

previously discussed at the ADTC. Roxadustat would be used in the same cohort of patients that would otherwise be receiving Darbepoetin. The Shared Care Group was content that there would be no additional resource requirements within Primary Care.

The Shared Care Agreement has been brought to the ADTC for approval of the clinical content. It was noted that negotiations with regard to inclusion in the local enhanced service contract would continue separately.

The ADTC approved the Shared Care Agreement for Roxadustat.

7.3 Shared Care Agreement for Apomorphine

Mr Headspeath highlighted the Shared Care Agreement for Apomorphine. The Shared Care Agreement had been discussed and approved at a previous ADTC meeting and discussed at the GP Sub-Committee. Following discussions and approval by the GP Sub-Committee it has been brought back to the ADTC for noting.

An amendment to clarify the arrangements for sharps waste was noted as well as the inclusion of information on the APO-go POD device.

The ADTC noted the updated Shared Care Agreement for Apomorphine.

7.4 Shared Care Agreement for Darbepoetin

Mr Headspeath highlighted the Shared Care Agreement for Darbepoetin Alfa. The Shared Care Agreement had been discussed and approved at a previous ADTC meeting. Following discussions and approval by the GP Sub-Committee it has been brought back to the ADTC for noting.

The ADTC noted the updated Shared Care Agreement for Darbepoetin Alfa.

7.5 Guidance Documents on StaffLink

Mr Notman gave a verbal update on progress with regard to the work ongoing in conjunction with the Communications team and Specialties to identify medicines-related guidance documents and create a central repository to host these on StaffLink.

A search has been undertaken and over 3,500 guidance documents currently on StaffLink have been identified. These are currently being checked to establish relevance from a medicines perspective. A folder format on Stafflink similar to that used currently for FROG to be developed by the Communications team along with a standard operating procedure for the uploading of medicines-related guidance documents on StaffLink.

The ADTC noted the verbal update on progress with regard to creation of a central repository on StaffLink for the hosting of medicines-related guidance documents.

8 Patient Safety Programmes

8.1 Anticoagulant Patient Safety Programme

The ADTC requested that an update be brought to the February meeting as a substantive agenda item. **AW**

8.2 Lithium Patient Safety Programme

The ADTC requested that an update be brought to the February meeting as a substantive agenda item. **JB**

8.3 Valproate Patient Safety Programme

Mr Notman provided an update on progress in NHS Fife in response to the National Patient Safety Alert (NPSA) “Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients” issued on 28 November 2023.

A steering group co-chaired by Fiona Forrest, Deputy Director of Pharmacy and Medicines, Dr Helen Hellewell, Deputy Medical Director (H&SCP) and Dr Iain MacLeod, Deputy Medical Director (Acute) has been established to provide oversight to the operational group tasked with producing an action and improvement plan to document progress towards and delivery of the actions outlined in the NPSA by 31 January 2024.

The initial meetings of the steering group and operational group were held in mid-December and Terms of Reference and initial action plan produced.

A discussion followed and Mr Notman provided an update on progress with regard to the multi-specialty work ongoing to ensure that the legislative requirements of the NPSA are met.

The ADTC noted the update on behalf of the Valproate Patient Safety Programme.

8.4 Insulin/Diabetes Patient Safety Programme

Mr Notman provided an update on behalf of the Insulin/Diabetes Safety Programme.

The group is now fully established with multidisciplinary team membership, with monthly meetings held to discuss recent incidents and plan future improvements.

A number of actions have been taken forward within the Acute Service and various insulin guidance documents produced. A main focus of the group for the next six months is community insulin prescribing.

Communications and guidance has also been distributed in respond to the recent National Patient Safety Alert: Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba®) products**.**

The ADTC noted that the action plan for the group requires further development/expansion. Mr Notman to feed back to the group. **FN**

The ADTC noted the update on behalf of the Insulin/Diabetes Safety Programme.

8.5 High Risk Pain Medicines Patient Safety Programme

Mr Hannan introduced the update on behalf of the High Risk Pain Medicines Patient Safety Programme and highlighted key points.

It was noted that project level plans have now been established for most activity. There are no current risks or issues that require strategic support/escalation.

The ADTC noted that update on behalf of the High Risk Pain Medicines Patient Safety Programme and the good work progressing.

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 update to the current management actions. All current Shared Care Protocols have been sent to specialities for a review of safety pending a more complete review being carried out. A meeting took place between Mr Hannan, Dr Hellewell and Mr Notman to discuss the process for review of existing and new Shared Care Agreements. An updated Policy & Procedures flow chart is being developed which will be brought to the ADTC in due course. A discussion followed and it was noted that the main risk related to review of existing Shared Care Protocols. The ADTC discussed the RAG status and agreed that the target had not been met and the likelihood status should be increased to 4. The management action to be updated to articulate discussions between Mr Hannan, Dr Hellewell and Mr Notman around the review process and recovery plan. Mr Hannan, Dr Hellewell, Mr Notman and Dr McCormack to discuss and provide an update to the ADTC in February. Management actions to be delivered by April 2024. **FN/BH/ HH/SM**

Risk 1504 - Lack of a Central IT Location to Store Guidance Documents
The ADTC discussed the update to the current management actions. The ADTC was comfortable with the descriptor of the risk and the work ongoing by Pharmacy and the Communications team. Management actions to be updated with the detail following the search undertaken on StaffLink. The current RAG status to remain red. To be brought back to the ADTC in June 2024.

Risk 1575 - Input into Medicines Management and Governance
The ADTC discussed the update to the current management actions. No changes to the risk description or RAG status were proposed. ADTC Terms of Reference and membership to be reviewed. Risk to be brought back to the ADTC for review in June 2024. **BH/FN**

Risk 1621 - Medicine Shortages
The ADTC discussed the update to the current management actions. It was noted that the number of medicine shortages continues to be an issue. The medicines shortages protocol is currently being reviewed and will be a single system approach to medicines shortages for Primary Care and the Acute Service. Following recent ADHD medicine shortages further areas requiring improvement were identified and the protocol is being revised accordingly prior to bringing to the ADTC. It was agreed that no changes to the risk description or RAG status were required. To be brought back to the ADTC in April for review.

Risk 2034 - East Region Formulary
It was agreed that risk 2034 should be refined and brought back to the ADTC.

10 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

10.1 Scottish Government Consultation "Quality Prescribing for Respiratory 2024 - 2027" - NHS Fife Response

The ADTC noted the NHS Fife response to the Scottish Government Consultation "Quality Prescribing for Respiratory 2024 - 2027".

10.2 ADTCC September/November 2023 Newsletter

The ADTC noted the ADTCC Newsletter September and October 2023.

11 EFFECTIVE PRESCRIBING

11.1 Medicines Procurement Newsletter

The ADTC noted the Medicines Procurement Newsletter September 2023.

11.2 NCMAG Quarterly Update

The ADTC noted the NCMAG quarterly update October 2023.

11.3 NCMAG 106 Nivolumab

The ADTC noted the NCMAG 106 Nivolumab Advice Document

11.4 NCMAG 107 Dabrafenib plus trametinib

The ADTC noted the NCMAG 101 NCMAG 107 Dabrafenib plus Trametinib Advice Document.

11.5 Health Economic Considerations in NCMAG Decision Making

The ADTC noted the NCMAG report Health Economic Considerations in NCMAG Decision Making.

12 HEPMA Update

Mr Wilson provided a verbal update on the current contractual position and progress with implementation of HEPMA. The ADTC noted that the contract for provision of a HEPMA service has been signed.

13 PACS/SMC Non Submissions

13.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

14 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee.

15 ANY OTHER COMPETENT BUSINESS

Mr Hannan highlighted that Ms Fernie was stepping down from her role as ADTC patient representative. Mr Hannan thanked Ms Fernie for her valuable input to the ADTC over the previous five years.

Other Information

a **Minutes of Diabetes MCN Prescribing Group** 28 November **2023**. For information.

b **Minutes of Heart Disease MCN Prescribing Sub-Group** 24 August 2023 and 23 November 2023. For information.

c **Minutes of Respiratory MCN Prescribing Sub-Group** 25 October **2023**. For information.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 7 February 2024 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by 24 January.

AREA DRUG & THERAPEUTICS COMMITTEE (Meeting on 7 February 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Area Drug & Therapeutics Committee

UNCONFIRMED

MINUTES OF THE MEETING OF THE FIFE DRUGS AND THERAPEUTICS COMMITTEE HELD ON WEDNESDAY 7 FEBRUARY 2024 AT 3.00PM VIA MICROSOFT TEAMS

Present:
Mr Ben Hannan (Chair)
Dr Caroline Bates
Dr Helen Hellewell
Dr Sally McCormack
Mr Fraser Notman
Ms Olivia Robertson
Ms Rose Robertson
Ms Andrea Smith
Ms Amanda Wong

In attendance:
Mr John Brown (item 7.3)
Ms Niamh Morrison (items 7.1, 7.3)
Ms Sandra MacDonald, Administration Officer (minutes)

ACTION

1 WELCOME AND APOLOGIES FOR ABSENCE

Mr Hannan welcomed everyone to the February meeting of the ADTC.

Apologies for absence were noted for Dr Ian Fairbairn, Dr Iain Gourley, Dr David Griffith, Dr John Morrice, Doreen Young.

Mr Hannan highlighted that Doreen Young was standing down from the Committee due to retirement. Mr Hannan thanked Ms Young for her valuable contribution to the ADTC.

2 MINUTES OF PREVIOUS MEETING ON 20 DECEMBER 2023

The minutes of the meeting held on 20 December 2023 were accepted as a true record.

3 ACTION POINT LOG

It was noted that all action log items scheduled for update have been included on the agenda.

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.

Review of the paediatric chapters is continuing, with review of the paediatric Endocrine and Skin chapters nearing completion. The next paediatric chapter scheduled for review is Blood and Nutrition and chapter expert working groups are being established to take this forward. It is anticipated that all paediatric chapters will be finalised by September/October 2024.

Business as usual is continuing with new Formulary Application Forms reviewed and approved at each ERFC meeting. It was noted that a time and motion exercise is being undertaken to look at workload implications of business as usual and a potential move towards an East Region collaborative.

Mr Hannan highlighted national work ongoing relating to transition to regional formularies and optimising the use of medicines.

The ADTC noted the update from the East Region Formulary Committee and the minutes from the meeting on 13 December 2023.

6.2 MSDTC

Dr McCormack introduced the update report on behalf of the MSDTC and highlighted key points.

The ADTC noted the current progress and the workplan for the next six months. There were no items from the MSDTC meeting in December that required escalation to the ADTC.

The ADTC noted the update on behalf of the MSDTC and the minutes from the meeting on 13 December 2023.

6.3 Non-Medical Prescribing Group

6.3.1 Updated Non-Medical Prescribing Policy

Ms Wong introduced the update report on behalf of the Non-Medical Prescribing Group and highlighted key points.

The ADTC noted that the Non-Medical Prescribing Policy has been updated to reflect changes in legislation for Controlled Drugs and a communications plan to launch the Policy has been developed.

A central database for registration of all Non-Medical Prescribers in NHS Fife has been developed and implemented. This has facilitated the development of a robust governance process to clarify and enhance the registration and budgetary procedure for all non-medical prescribers.

The workplan for the next six months includes a communication and drop in session for podiatrists, physiotherapists and paramedics in Fife to update on changes in controlled drugs legislation and implications for practice and implementation of the communications plan for launch of the Policy.

It was noted that several amendments required to be made to the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) to reflect changes in legislation for Controlled Drugs. A cross-check to be made to ensure that the SSUMPP and Non-Medical Prescribing Policy remain synchronised in terms of changes and requirements. **AW/AS**

Ms O Robertson noted a change within the administration team involved in maintaining the database due to retirement. The ADTC noted the continency arrangements in place.

The costs associated with distributing British National Formulary (BNF) paper copied to all Non-Medical Prescribers was also highlighted. Use of the on-line version of the BNF was advocated as this is regularly updated.

A discussion on the potential financial impact of increased non-medical prescribing, quantification of benefit to patient care and audit and assurance work followed.

The ADTC noted the update report on behalf of the Non-Medical Prescribing Group and approved the changes to the Non-Medical Prescribing Policy.

6.4 Shared Care Group

Mr Notman introduced the update report on behalf of the Shared Care Group and highlighted key points.

The Shared Care Group is continuing to meet regularly and drive forward the review of current/development of new Shared Care Agreements. Updated Shared Care Agreements for Apomorphine for Parkinson's disease and Darbepoetin for renal anaemia have been completed. A new Shared Care Agreement for Roxadustat for renal anaemia is in the final stages of the review process and it will be brought back to the ADTC for noting in due course. A combined Hydroxychloroquine Shared Care Agreement is being taken forward in liaison with Dermatology and Rheumatology.

It was noted that Specialties have been requested to review existing Shared Care Agreements to ensure that they are clinically in line with current practice. A workplan and timeline for undertaking a full review will thereafter be developed.

The ADTC noted the update report on behalf of the Shared Care Group.

7 SBARs/Updates

7.1 Melatonin Prescribing Update

Mr Notman took the ADTC through the melatonin prescribing update report and highlighted key points.

Proposed projects to address melatonin prescribing in NHS Fife were highlighted (a switch from Circadin MR 2mg tablets to more cost-effective generic melatonin MR 2mg tablets which was implemented in 2023/24; a switch from melatonin 3mg capsules to tablet formulation which is no longer being progressed). National discussions around melatonin liquid were also highlighted.

The workplan for the next six months includes discussions with the Mental Health Team and Mental Health Clinical Director regarding clinical review of melatonin prescribing and the ongoing review to ensure that efficacy is maintained.

The ADTC noted the request to close off the current action regarding melatonin prescribing efficiencies and undertake a deeper review of melatonin prescribing and actions that can be taken to rationalise prescribing where clinically appropriate.

The ADTC noted the melatonin prescribing update report and agreed that the current action with regard to melatonin prescribing efficiencies should be closed. A deeper review of melatonin prescribing to rationalise prescribing where clinically appropriate to be taken to the Prescribing Forum for discussion.

7.2 Valproate Patient Safety Programme

Mr Hannan thanked everyone involved in the work undertaken in response to the National Safety Alert (NatPSA/2023/013/MHRA).

Mr Notman took the ADTC through the action plan which has been aligned to the actions set out in the National Patient Safety Alert, along with associated appendices (Terms of Reference for the Valproate Safety Operational Group and Valproate Safety Steering Group; list of guidance documents on StaffLink that reference valproate; and valproate prescribing pathway). Draft protocols for each Specialty along with guidance for GP practices and an in-patient pathway have also been produced by Tom McCarthy and Claire Berry from the Project Management Office in discussion with specialties.

The ADTC noted the actions completed, actions in progress and actions identified for implementation at a later stage.

Mr Notman highlighted that the protocols include a list of contraception methods that are considered as highly effective. A link to Faculty of Sexual and Reproductive Health guidance which provides information on other user-independent forms of contraception is also included within the protocols. The

ADTC noted that comprehensive advice is provided within the documentation and specialist judgement would be made on an individual patient basis.

Mr Hannan highlighted a change to the action plan to clarify that an additional meeting of Valproate Safety Steering Group would be arranged. Thereafter the Valproate Safety Operational Group would report through the Medicines Safety and Policy Group.

The ADTC noted the updated action plan and was assured of NHS Fife's response to the National Patient Safety Alert. Continued assurance to be received through progression of the actions. An update to be brought back to the next ADTC meeting.

7.3 Lithium Patient Safety Programme

Ms Morrison introduced the SBAR NHS Fife Progress against SGHD/CMO(2019)4 – National Guidance for Lithium Monitoring and highlighted key points.

The report was produced to provide an update to the ADTC on the progress within NHS Fife for managing patients against the Scottish Government Lithium Monitoring Guidelines issued in 2019 (SGHD/CMO(2019)4) and agree ongoing reporting pathways through the Medicines Safety Programme to the Medicines Safety and Policy Group and ADTC.

A Lithium Safety Group has been set up and an action plan identified for managing adherence to the national lithium monitoring guidance. The Shared Care Agreement for Lithium Management has been updated and submitted to the Shared Care Group for review.

The ADTC noted the update on progress within NHS Fife for managing patients within Fife against the 2019 national guidelines and agreed to the reporting route outlined in the SBAR. Updates to be provided as part of the Medicines Safety and Policy workplan.

8 Risks Due for Review in Datix

There were no risks scheduled for review.

9 ADTC-COLLABORATIVE/SCOTTISH GOVERNMENT COMMUNICATION

None for noting.

10 EFFECTIVE PRESCRIBING

10.1 Diabetes Prescribing Strategy

The ADTC noted the Diabetes Prescribing Strategy.

10.2 NCMAG Quarterly Update

The ADTC noted the NCMAG quarterly update January 2024.

10.3 NCMAG 111 Sunitinib

The ADTC noted the NCMAG 111 Sunitinib Advice Document.

10.4 NCMAG 112 Pazopanib

The ADTC noted the NCMAG 112 Pazopanib Advice Document.

11 HEPMA Update

Due to time constraints the HEPMA update was deferred to the next ADTC meeting.

12 PACS/SMC Non Submissions

12.1 Latest Submissions

The table detailing the latest PACS2/SMC non submissions was noted.

13 POINTS FOR RAISING AT CLINICAL GOVERNANCE COMMITTEE

There were no items identified as requiring escalation at this stage to the Clinical Governance Committee.

14 ANY OTHER COMPETENT BUSINESS

There was no other business.

Other Information

a **Minutes of Diabetes MCN Prescribing Group -** next meeting 27 February 2024.

b **Minutes of Heart Disease MCN Prescribing Sub-Group -** next meeting 18 April 2024

c **Minutes of Respiratory MCN Prescribing Sub-Group 31 January 2024** - not available.

d **Date of Next Meeting**
The next meeting is to be held on **Wednesday 17 April 2024 at 2.00pm via MS Teams**. Papers for next meeting/apologies for absence to be submitted by *3* April.

QUALITY & COMMUNITIES COMMITTEE

(Meeting on 17 January 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
WEDNESDAY 17 JANUARY 2024, 1000hrs - MS TEAMS

Present:	Councillor Rosemary Liewald (Chair) Councillor Margaret Kennedy Councillor Sam Steele Councillor Margaret Kennedy Paul Dundas, Independent Sector Lead (PD) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG) Alistair Grant, Non-Executive Board Member (AG)
Attending:	Nicky Connor, Director of Health & Social Care (NC) Dr Helen Hellewell, Deputy Medical Director (HH) Roy Lawrence, Principal Lead for Organisational Development & Culture (RLaw) Catherine Gilvear, Quality Clinical & Care Governance Lead (CG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Fiona McKay, Head of Strategic Planning, Performance and Commissioning (FMcK) Rona Laskowski, Head of Complex and Critical Care Services (RL) Vanessa Salmond, Head of Corporate Services (VS) Audrey Valente, Chief Finance Officer, HSCP (AV) Amanda Wong, Director of Allied Health Professionals (AW) Avril Sweeney, Risk Compliance Manager (AS) Dougie Dunlop, Independent Chair of the Child Protection Committee (DD) Hilary Munro, Professional Head of Service, Speech and Language Therapy (HM) Jacquie Stringer, Service Manager (Locality/Community Led Support) (JS)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Sinead Braiden, NHS Board Member (Chair) (SB) Lynn Barker, Director of Nursing (LB) Councillor Lynn Mowatt Ian Dall, Service User Rep, Chair of the PEN (ID) Christine Moir, Head of Education and Children's Services (Children and Families/CJSW and CSWO) (CM)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS**	

	Cllr Liewald informed those present, Sinead Braiden was unable to join the meeting and she had been asked to step in as Chair. She welcomed everyone to the January HSCP Quality & Communities Committee.	
2	**ACTIVE OR EMERGING ISSUES**	
	Helen Hellewell stated there were no emerging issues to advise the Committee of.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**LIVED EXPERIENCE**	
5.1	**Lived Experience – Head and Neck Cancer** This subject matter was brought to Committee by Lisa Cooper who introduced Hilary Munro, Professional Head of Service, Speech and Language Therapy. She advised the presentation came through QMAG, celebrating the success which has been realised through the dedicated care for people experiencing Head and Neck Cancer Treatment. The item was presented by Hilary Munro, Roy Lawrence supported with the video. The Patient Story is shared with full consent from the patient involved. HM advised the Head and Neck Cancer work within Speech and Language Therapy is led by Rachel Swan, who won the NHS Fife Staff Award for Service Improvement. HM provided background to the Service and the impact of the commitment to implement the National Cancer Quality Work Programme. She spoke of funding challenges within Speech and Language Therapy, the Development Plan which was agreed and the journey this took the Service on. Patient involvement, quality improvement methodology and robust data collection was integral to the development of the Pre-habilitation Service. HM reported now, 95.6% of newly diagnosed patients in Fife are seen prior to their Head and Neck cancer treatment, a ten-fold increase. She stated, Fife is the top performing Board in Scotland and strive to meet and exceed the 90% target. Patient feedback around the pre-habilitation services is excellent. HM told the story of a tongue cancer patient's journey and the support provided prior to surgery. She explained the expected impact of a full tongue removal and the many resulting difficulties for the patient. Extensive work was put in place to enable the patient to use her own voice to communicate going forward. The technology used and work involved was explained. A video was played of the patient post-surgery where she is able to explain, using her own voice, the support she has received from the Service.	

	Questions were invited. Cllr Kennedy, having had previous experience as an ENT Nurse, ward and theatre, gave thanks for the presentation and felt it was very powerful. She hoped this model will be used extensively. Cllr Liewald praised the team for their extensive work and thanked the patient for sharing her story.	
6	**MINUTES OF PREVIOUS MEETINGS HELD ON 02 NOVEMBER 2023** The previous minutes from the Q&CC meeting on **02 November 2023** were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
7	**ACTION LOG**	
	The Action Log from the meeting held on **02 November 2023** was approved as accurate and updates provided were noted. HH advised an update around the Re-Phasing of the Flu and Covid Vaccination Programmes will come to the next meeting on 08.03.24. Also, the OT Waiting Times Update.	
8	**GOVERNANCE**	
8.1	**Quality Matters Assurance** The report was brought for assurance by HH in Lynn Barker's absence. HH gave an overview of the current clinical and care governance arrangements, systems and processes which are in place across the Partnership and outlined the matters discussed at Fife HSCP QMAG. The paper also represents the 4 Quality Matter Assurance Huddles which have been held in the last reporting time. HH highlighted good discussion around the role of the Principal Social Worker and how this will influence matters going forward, providing a robust framework. She referred to the excellent feedback from the Mental Welfare Commission from the inspections which are referred within the paper presented. CG drew attention to the good work around the adverse events relating to incidents within the Partnership and improved compliance to target dates. MF asked for any acronyms be explained in full the first time they are used. CG will bear in mind for future papers. The Committee were Assured by the report.	
8.2	**Deep Dive Risk Review – Demographics/Changing Landscapes Impacts** This report was brought to Committee by Audrey Valente for Discussion and Assurance. AV advised, as part of the IJB Risk Management Policy and Strategy a Risk Reporting Framework is in	

	development, each Risk on the IJB Strategic Risk Register is assigned to either Q&CC or the Finance, Performance & Scrutiny Committee, or both. A Risk Register Report will come to Q&CC twice per annum and a Deep Dive Risk Review will come quarterly. AV advised a Deep Dive Review on Primary Care came to Q&CC on 07 Sept '23 and explained the purpose of the Deep Dive Risk Review is to give assurance Risks are being effectively managed within the IJBs agreed Risk appetite and at the appropriate tolerance levels. AV outlined the scoring used and the questions set which are to aid members on their scrutiny of the Risks. AV spoke of the mitigating actions and links to the Transformational Change Programme and implementation and roll out of the key enabling strategies which support delivery of the Strategic Plan. There were no questions from Committee.	
8.3	**IJB Quality and Communities Strategic Risk Register** This report was brought to Committee by Audrey Valente for Discussion and Decision. AV explained the report sets out the Strategic Risks which may pose a threat to the Partnership in achieving its objectives in relation to clinical and care governance in delivery of care. The Committee was asked to agree the closure of Risk 15, the Participation and Engagement Risk, as SMART actions have been completed and the Risk has been reduced to target levels. AV explained the Risks held on the register continue to be managed by the Risk Owners and were most recently reviewed Dec '23. Currently there are two Risks with a high residual score, PC Services Risk and Demographic Changing Landscapes Risk. Deep dives have been conducted on both. AV referred to the Risks at an operational level and advised these are monitored regularly at QMAG and actively managed by Service Managers. Any concerns are escalated to SLT. AG queried when a Risk becomes a reality. AS explained, at a strategic level, are managed as an issue with mitigating actions put in place. All actions will be noted within the register. NC agreed with AS and felt the Risk would be reframed and the specific issue would be dealt with. CG advised, the full Appendices have not come through in the Papers. AS will circulate the relevant files. Cllr Liewald confirmed the Committee were content with the Strategic Risk Register.	**AS**
9	**STRATEGIC PLANNING & DELIVERY**	
9.1	**Transformation Update: Transforming Overnight Care**	

	This report is brought to Committee by Rona Laskowski. It comes for Information and Discussion. RL advised the paper is an update to the Transformation of Overnight Care which came to November '23 Committee. Comments and feedback have been noted and explored, resulting in amendments where required and the Paper continues its journey through Governance. RL recapped on the model of care currently available and the proposed transformation. Cllr Liewald thanked RL for the report and was appreciative of the workshops which provided extra information to members. PD advised he has discussed Risks with employers/providers and sleepover sustainability. RL spoke of work to be taken through the Proposed Providers Forum to fully understand implications. Cllr Kennedy commented on the quality improvements made and was encouraged to see the emphasis around agreement of an assessment outcome. She queried the Business Continuity Plan and staff safety. RL gave assurance these aspects have been considered and spoke of work which has taken place. The Q&CC agreed they are supportive of continuing to support the Transformation of Overnight Care in its journey through Governance.	
10	**LOCALITIES**	
10.1	**Locality Planning Progress - 2023** The report is brought to Committee by Fiona McKay. It comes for Assurance and Decision. FMcK introduced Jacquie Stringer, Service Manager (Locality/Community Led Support), who explained she came into post in 2022 to continue work on locality planning, post Pandemic. By the end of 2022, staff were recruited to support Locality Planning Groups. She stated, by the beginning of 2023, there were 3 Local Development Officers recruited to support the Groups which made a fabulous impact upon Locality Planning. The Groups meet quarterly, with one wider stakeholder event each year. JS spoke of the work the SLWGs do to produce outcomes for Locality Planning. JS spoke of the work which has taking place, including launch of the Community Chest Fund (CCF), a Fife wide initiative which has provided locality planning groups the opportunity to support and engage with unpaid carers. Community engagement events in Cowdenbeath and Glenrothes have taken place and a test of change took place in North East Fife to support people with long term conditions. JS explained the opportunity for Professionals to refer patients to a single point of access (The Well) for community led support. JS added, Locality Planning plays a key role in maintaining positive relationships between HSCP, Fife Council, NHS Fife and the Third and Independent Sectors. Evidence is provided in the annual report 2023 of work being carried which highlights the positive impact achieved by	

	multi agency working. JS spoke of the key areas of work to be carried out in 2024 and beyond. JS proposed Locality Planning undertakes a two-year planning cycle. One annual event a year to bring together locality planning and show case what work has been done and a wider stakeholder event every 2nd year which will use local intelligence and data to inform priorities. MF voiced concern the wider stakeholder meetings may be moved to bi-ennial rather than annual. She felt, even an annual meeting is rather limited. She felt public involvement could be lost through moving to biennial. Reporting cycle could move to 2 years but the events kept at annual. FMcK wanted to bring all localities together this year to enable learning. Stakeholder events, which are only for one locality, will move to two years, with the bigger event involving all localities, giving greater learning, will move to bi-annually. However, MF's view will be taken on board and discussed further. JS suggested a SLWG to consider options, MF invited to be involved. Cllr Liewald confirmed the Committee are happy for the paper to progress.	
11	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
11.1	**Fife Child Protection Committee Annual Reports - 2021/22 & 2022/23** The reports were brought to Committee by Dougie Dunlop, Independent Chair of the Child Protection Committee for Assurance**.** DD introduced the report and gave background, explaining there has been changes to key personnel within the CPC over the past two years. This has had impact upon the pace of the developmental work being undertaken, the team is working hard to catch up and meet targets. The quality of intervention has remained high, borne out by the quality assurance work and work undertaken through SCIM (Scottish Child Investigative Model), who have provided very positive feedback. DD explained, over the past two years there has been a steady decline in the number of children involved in the Child Protection process, this is reflected across Scotland. Cause is unclear, however, DD felt this reflects the preventative services which have been developed over the past few years and gave examples. The main issue remains one of neglect with this being the problem for over 60% of children on the register, followed by MH, substance mis-use and domestic violence. Comparing Fife to the rest of Scotland, neglect is significantly higher, 63% compared to 43%. DD highlighted links between poverty and neglect. DD spoke of the priority areas for development during 2024 to include major procedural requirements and spoke of the great amount of time	

	this can consume. The three key practices to be taken forward are neglect, child sexual exploitation and Contextualised Safeguarding and listening to the voice of the child. Working groups have been reshaped moving into 2024 which DD explained. Questions were welcomed. Cllr Liewald praised DD for the work taking place and referred to the Corporate Parenting Board which she Chairs. MF commented on the appalling level of child poverty, particularly within Fife. She queried why Fife should be so much worse than Scotland as a whole. DD advised it was a difficult question to answer, however, because Fife are responding to a need and recording more data than other areas, could be a reason, also Fife has a higher number of instances of substance misuse and alcohol problems. Cllr Liewald agreed with DD's response. The Committee were Assured by the reports.	
11.2	**Director of Public Health Annual Report 2023 - Children and Young People in Fife: the Building Blocks for Health** The report is brought to Committee by Lisa Cooper and was presented by Dr Lorna Watson, Deputy Director of Public Health, Child Health Commissioner, NHS Fife. The report comes for Discussion. LW advised annually, the Director of Public Health produces a report of their choice. Joy Tomlinson chose Children and Young People. LW was happy to bring the report which explores and delves deeper into the data around Children and Young People and makes recommendations. She stated the report is written, not exclusively by Public Health, but by the people most closely working within the varying topics and edited by PH. The paper has been through the Governance Route and a launch event was held in September '23. The key themes of the report are UNCRC Children's Rights Bill, ensuring children/young people's voices are being heard in decisions made directly or indirectly involving them. Also, The Promise which requires a fundamental rethink in how public services are delivered to Care Experienced children and Looked After children to improve outcomes. LW spoke of the work being undertaken. LW spoke of child development and wellbeing, problems relating to child poverty/ inequalities which has become more acute with the cost of living increases. Recommendations were referred to. Questions were invited. Cllr Steele thanked LW for the report which she found very interesting. She referred to maternal health and birth and queried birth trauma and how this may initially impact the relationship between mother and newborn. LW was aware of	

	work within the maternity dept, she felt clinics had been established, (but will verify this with Councillor Steele), which considers birth trauma and provides support. LW will gather further information and report back to Cllr Steele. MF was pleased The Promise was mentioned and was aware of funding supporting Consultants. She believed there was a mapping activity being undertaken, she asked what work was being done to fulfil The Promise and if further funding is to be released. LG will contact colleagues and feed back to MF. LC advised, the Partnership's Children Services Plan, captures a lot the report 2023-26, and a Lead Officer has recently been appointed for The Promise. LC suggested, as the Plan is implemented, the Lead Officer could be invited to bring a paper to Q&CC. Councillor Liewald stated Fiona Morrison, who sits on Corporate Parenting Board, has been recently appointed as Lead Officer for The Promise. It was agreed this subject should be brought to Q&CC. CG thanked LW and the wider team for the detail within the report.	**L Watson** **L Watson**
11.3	**Care Inspectorate Grades for Social Care Services** The report is brought to Committee by Fiona McKay for Assurance. FMcK advised the report sets out care gradings given by the Care Inspectorate. She stated, new registrations or transfer of ownership requires the grading assessment to begin again, grades are not transferred over. An update on Care at Home gradings was provided, FMcK spoke of new Contractors who have been introduced. She advised, some of the providers are still to be inspected. It was explained, providers who may be experiencing difficulties are supported throughout investigations involving multi-disciplinary teams, including social work services. Questions were invited. PD stated there are providers who have not been graded over the past 2-3 years. He commented it is a changing picture and for some the grades have improved and some reduced since time of writing. He felt it would be useful to acknowledge, for the vast majority of the themes of the grades, the provider organisations are all graded at good or above, many at very good/excellent. He felt grades are significant in managing effectiveness and quality of improvement, however, do not tell the whole picture. He referred to being connected around collaborative and cooperative arrangements and supportive improvements for quality and effective care. He thanked FMcK and the team for all the work involved.	
11.4	**Mental Welfare Commission – Reports and Action Plans** The report is brought to Committee by Rona Laskowski for Assurance.	

	RL advised, 13 scrutiny visits took place between Jan – Nov 2023 across the range of Services – General Adults, Older Adult and Speciality Services. In general, feedback and commendation from the Welfare Commission was a change from previous scrutiny reports received. She stated, all reports acknowledged significant improvement seen from leadership through to care arrangements and the efforts made to address environmental conditions. RL felt the Service really has delivered and moved forward significantly. Particularly in terms of improvements in multi-disciplinary team working, patient and carer experience and robustness of the care and treatment offered. Also, improvement in compliance with legislation in recording. RL advised, particular acknowledgement was given regarding dementia friendly and dementia friendly environments being very advanced. An ongoing programme of refurbishment will take place over 2024-2025, seeing investment across 4 MH wards and an advancing programme for further environmental improvement. An issue raised was the need to improve use of surge beds. She felt, post pandemic impact is still having an effect with General Admission wards at full capacity. Also staffing levels are a concern. RL spoke of a vast range of activities taking place to address these issues. Cllr Liewald commented on the huge improvement seen and referred to the stresses upon staff. AG commented on a tour of Queen Margaret Hospital prior to Christmas, he felt it was obvious the stark differences in provision of care. She queried if something was being done. NC spoke of refurbishment of Adult MH wards and a programme of phased improvements. She would be delighted to invite AG back to Queen Margaret once these wards have been refurbished. NC spoke of improvement for patients and staff and the ongoing work. Councillor Sam Steele commented on the huge improvement seen at Mayfield Ward at Lynebank for both clients and their families. Particularly with the challenges within LD currently and wanted to comment on the positive improvement seen.	
12	**ITEMS FOR NOTING**	
12.1	**Chief Social Work Officer's Report** This report was brought to Committee by FMcK in Christine Moir's absence. It came for Noting and Assurance. FMcK commented, the Chief Social Work Officer's Report is a regular report which is required to come on an annual basis. FMcK referred to page 320 re the Partnership and the work of the Social Work Service within the Partnership. PD stated, the report includes ethical and collaborative commissioning, oversight and responsibilities of commissioning, however, does not reference size, scale and complexity. Queried if further information may be included to give the reader greater understanding. FMcK advised the report is prescriptive of what is to be reported. Jennifer Rezendes, Principal Social Work Officer will be close to the report	

	going forward. NC suggested PD contacts JR to discuss how we may influence going forward.	
12.2	**AHP Professional Documents** This report was brought to Committee by Helen Hellewell in Amanda Wong's absence. The report comes for Noting and Assurance. HH explained, operational and professional services have worked together to bring forward an assurance framework to meet professional and regulatory requirements, as well as meeting service delivery. The majority of AHP Colleagues are managed within the Partnership. It was suggested Annual reports on delivery come forward.	**A Wong**
13	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	13.1 Quality Matters Assurance Group Confirmed Minute from 06.10.23 **13.2 Clinical Governance Oversight Group** Unconfirmed Minute from 03.11.23 **13.3 Fife Drugs and Therapeutics Committee** *October meeting was cancelled* **13.4 Equality & Human Rights Strategy Group** Confirmed Minute from 10.11.23	
14	**ITEMS FOR ESCALATION** NC commented very good reports have come to Committee which she felt was assuring and should be highlighted to the IJB. Particularly the Lived Experience and Deep Dive reports.	
15	**AOCB**	
16	**DATE OF NEXT MEETING**	
	Friday 8th March 2024, 1000hrs, MS Teams	

RESILIENCE FORUM

RESILIENCE FORUM

(Meeting on 7 December 2023)

Points of Note

1. Business Continuity (BC) Management systems "live dashboard" was launched across NHS Fife on the 14 November. This forms a central part of the new strategic & proactive approach to Business Continuity governance and assurance procedures across NHS Fife.

2. NHS Fife's Hospitals Lockdown Framework has been endorsed for use by resilience forum stakeholders

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

NHS Fife

Minutes of NHS Fife Resilience Forum held on Thursday 07th December 2023 at 1400hrs via Microsoft TEAMs

Chair:
Joy Tomlinson, Director of Public Health, NHS Fife **(JT)**

Present:

Malcolm Landells, Resilience Advisor (East) Scottish Ambulance Service	**(ML)**
Allan Young, Head of Digital Operations, NHS Fife	**(AY)**
Lynne Parsons, Employee Director of NHS Fife	**(LP)**
Craig Burns, Emergency Planning Officer, NHS Fife	**(CB)**
Donna Baillie, Scottish Ambulance Service	**(DB)**
Kirsty MacGregor, Associate Director of Communications, NHS Fife	**(KMcG)**
Susan Cameron, Head of Resilience, NHS Fife	**(SC)**
Jimmy Ramsay, Head of Sustainability, NHS Fife	**(JR)**
Hazel Close, Head of Pharmacy, NHS Fife	**(HC)**
Lynne Garvey, Head of Community Care Services, NHS Fife	**(LG)**
Morag Shaw, Scottish Ambulance Service	**(MS)**
Sharon Doherty, Consultant Psychologist, NHS Fife	**(SD)**
Susan Fraser, Associate Director of Planning & Performance, NHS Fife	**(SF)**

In Attendance:
Stevie Rutherford, Personal Assistant, NHS Fife (Minute Taker) **(SRR)**

Agenda Item **Action**

1. Welcome and Introductions

JT opened the forum.

2. Apologies

Nicola Robertson, Fiona McKay, Donna Galloway, Paul Bishop, David Miller, Alison Henderson, Olivia Robertson, Aileen Boags, Ian Campbell, Maggie Currer, Margo McGurk

3. Minutes of previous meeting (10th October 2023)

JT asked colleagues for any comments to be returned in one week. If no comments were received the minute would be accepted as an accurate record of the meeting.

3.1 Action Tracker from 10th October 2023

SC provided an overview of work within the Tracker

- Severe Weather Framework – item 7.2 on the agenda.
- Business Continuity Planning –dashboard launched 14th November and the Standard Operating Procedure (SOP) is on the agenda.
- Vulnerable Person's – Patient at Risk Database - on the agenda.
- Bomb Threat & Suspicious Package – a stakeholder document in preparation, and the team are working on a flowchart for emergency evacuation, this will be brought back to a future meeting.

- Lockdown Framework –this will be discussed at 7.1 on the agenda.

4. Matters Arising

4.1 Communication between Scottish Health Boards during Major Incident and Major Incident with Mass Casualties (SAS)

DB provided an overview of the Communication Plan, which is a joint plan between Scottish Ambulance Service (SAS) and NHS Scotland. It includes all territorial and special Health Boards. The plan was developed in 2018 and has since had various updates. The rational was to formalise process of how the ambulance service notifies Health Boards of either a major incident or major incident with mass casualties. If a major incident is declared within one geographical Health Board then the geographical Health Board would be notified of this, but if a mass casualty, then all Health Boards would be notified. Communications would be further cascaded to NHS 24 and the Scottish National Blood Transfusion Service. Mass Casualty plan would be implemented at this stage. Testing process is carried out 4 times a year and the results of the tests are collated and sent onto every Health Board, this provides an assurance for Health Boards. The ''initial notification'' process is a single point of contact number which the control room has access to every Health Board in Scotland. DB provided an overview of ''Tactical Contact'' when this level is reached SAS will deploy a Tactical Medical Advisor to the ambulance control room. Their task is to make contact with all Health Boards and liaise with casualty control. DB explained that testing the plan takes over an hour to complete. DB advised that the next test will be carried out w/c 11th December, 2023.

5. Resilience Governance & Assurance

5.1 Business Continuity Systems Management (BCMS) Draft SOP

CB explained that a new Standard Operating Procedure (SOP) has been created which will support the Business Continuity Management System which was implemented on the 14th November, 2023. This has been put in place following stakeholder feedback. All managers and senior managers with access should be able to see a live snapshot of the system. SC commented this replaces the previous assurance procedure for business continuity which, was introduced during the pandemic. The system which is being put in place starts with individual areas sending their business continuity plans to the Resilience mailbox along with any requests for impact analysis of service areas. These plans will then be uploaded into Datix and the Resilience team will manage the system on behalf of managers/plan owners. The new system generates a dashboard which shows a live snapshot of the number of business continuity plans which are up to date and individual areas compliance. The Forum was asked to consider if a Business Continuity Quarterly Report based on an extract of the dashboard would be helpful and this was agreed.

5.2 Q2 EPRR Resilience Report & 2023-24 EPRR Training Plan

SC provided an overview of the live status of business continuity plans. There are currently:

- 141 active business continuity plans
- 58 are green and have been reviewed within the last year,
- 77 red which required to be updated.
- 5 areas are marked as grey, no plans received
- One area shown as plan in progress.

LG advised that she reviews every Business Continuity plan along with LK and Avril. 95% of the plans have been reviewed in the past year, LG requested that LK is given access to the folder containing the business continuity plans

A link will be sent out to mangers for the dashboard which will prompt monitoring of their own position every month. The resilience team have created Generic business continuity action cards which will support the development of plans for specific topics eg flooding. Quarterly report will go to EDG so they may be able to further comment.

Hospital Lockdown is on the agenda and this will also be a focus of training and education in future. Incident Management Framework training dates are to be identified, this will entail a video presentation that will be shared with staff. Loggist training has been undertaken and most of the loggists have completed online modular training, A workshop will commence in February 2024 alongside colleagues from East of Scotland Resilience partners.

SC highlighted the Forth Ports maritime mass casualty exercise referenced in the Quarter 2 report has taken place and this was reported to have went well. Resilience team members have also been involved in the multi agency nuclear response scenario.

SC highlighted the Prevent training figures are within the quarterly report, and advised that Police Scotland will be continuing to provide face to face Prevent sessions for NHS colleagues. These are mainly run at Victoria Hospital Kirkcaldy and Queen Margaret Hospital Dunfermline, course dates advertised on Stafflink.

ACTION – Forum members to feedback on how communications would like to be taken forward for areas expired on plans. **ALL**

ACTION - Forum members to comment on the ‘’training and exercising plan across 2023-2024’’. **ALL**

6. Whole System Overview

6.1 H&SCP

LG advised she chairs the Health and Social Care Partnership resilience assurance group, this has been in place since March 2022, meetings are quarterly, focusing on the action plan and giving assurance to the IJB in order for them to fulfil category 1 responder status and short life working groups established to work on emerging areas of work.

LG has launched the Health and Social Care Partnership resilience framework, formal approval from IJB and through several committees. Furthermore quarterly Prevent figures are received, and in turn relayed to Senior Leadership Team (SLT) for assurance. Furthermore, Fife Council employees are undertaking Prevent training as part of their ongoing development.

LG advised she continues to send representatives to various workshops such as fuel resilience and operation waypoint. Particular focus on the risk preparedness.

LG advised she will convene a short life working group to take the new process of assessment against the 12 common consequences to help inform the LRP capability gap. LG reported the action to support PARD is sitting with the Council, but nothing yet to expand to health, more updates to follow likely in January 2024.

SC advised a short life working group including NHS 24 was established where health

and social care partners have supported a flowchart of triggers for major incident response. This covers any incidents where NHS 24 would be contacted for partner agency support. NHS 24 can provide support to assist in reducing footfall at hospitals or to redirect patients if we are faced with a mass casualties surge in any major incident event. LG will be looking at where flow and navigation sits in the near future, this will likely be hosted by emergency care department.

6.2 Acute Services

Apologies were received from Acute representatives for this meeting. SC provided a brief update that a piece of work is to being progressed on surge planning and major incidents with mass casualties.

6.3 Scottish Ambulance Service (SAS)

ML advised the forum that there are various exercises Scottish Ambulance Service (SAS) will be involved with in coming months, including Prevent. ML provided a wider update on continuing work to prepare for the winter ahead, new recruits have joined the service and the winter vaccine programme has been rolled out. A civil contingency response team programme has been launched, this is a extension to the Specialist Operations Response Team (SORT) capability in which regional colleagues are trained to wear the Powered Respiratory Protection Suits (PRPS) and setting up of decontamination tents. This is done in collaboration with special operation paramedics.

6.4 Climate Change Risk Analysis (CCRA) Sustainability

JR advised his team attended the Fife COP event which was hosted by Sustainable Scotland Network and Fife Council, climate adaptation was a highlight of the event. JR explained a company named ‘’Sniffer’’ have been given funding from the Scottish Government and the UK shared prosperity fund to support 6 local authorities and to develop their climate change plans if they do not have them. JR continuing to work with Fife Council. Two sustainability officers attended the Botanic Gardens in Edinburgh to learn about the nature based flooding. JR will progress solutions for areas prone to flooding in 2024. JT asked if there would be benefit in developing a business continuity action card for ‘’heat’’. SC noted this and will take JT and JR’s comments on board. CB advised heat exhaustion and other issues are referenced within the Severe Weather document, CB would welcome feedback from JR on the new Severe Weather document.

ACTION – JR to feedback to CB on Severe Weather document **JR**

6.5 Digital and Information

AY provided an overview on Digital issues. The national cyber security centre threat status remains high across the UK as a consequence of ongoing geo-political issues. On average there are 21 cyber incidents and 8 new vulnerabilities detected every month. In regards to the cyber security operation centre and cyber resilience early warning alerts have been at normal levels over the last quarter. Work continues on response for the service catalogue. An exercise and penetration test was carried out in August and September 2023 and an action list has been created from the findings. AY reported christmas change freeze will operate from 15th December until 08th January.

7. Emergency Plans

7.1 Lockdown Framework (a) Final Draft & (b) Stakeholder checklist

CB provided an overview on the lockdown framework, which is in its final draft, currently awaiting final feedback from Senior Leadership Team x2 (SLT) which received the draft framework on the 13th and 14th November respectively. The deadline for responses is 12th December, no feedback or comments back so far. This framework document also links into the bomb threat framework. The framework will become particularly important when Martin's Law is implemented, training will be led by the security team from Victoria Hospital, Kirkcaldy, and assessments have taken place in Victoria Hospital, Kirkcaldy and Queen Margaret, Dunfermline. JT advised any comments back to CB by the 15th December from forum members.

ACTION – Forum members to feed back any comments to CB **ALL**

7.2 Severe Weather Framework (SWF) Draft

CB advised the forum that this is the start of the feedback and consultation period for this new framework document. Stakeholder feedback has been received already from colleagues and incorporated into the framework document. Action cards for managers incorporating staff safety, and pharmaceutical fridge checks have been created. The framework also reflects the communication plan and feedback which has already been provided from KMcG and the communications team. The timescale for stakeholder feedback will be 15th January, 2024.

ACTION – Stakeholder feedback 15th January **ALL**

8. National EPRR Updates

8.1 NHS Scotland Resilience: Business Continuity Strategic Guidance for NHS Health Boards in Scotland – October 2023

SC provided an overview of the 2 published Health EPPR documents.
The Business continuity Strategic Guidance for NHS Health Boards has been reworked and published on the EPRR website for viewing , https://app.joinblink.com/#/hub/357c2b4b-96c5-4bae-905d-224108e7f313. Wider strategic guidance in relation to our contracted services including PFI providers. Work will be progressed on risk profiling for NHS Fife.

8.2 Preparing for Emergencies – Guidance for Health Boards in Scotland: November 2023

SC advised on preparing for emergencies, this is out for guidance for NHS Health Boards in Scotland, this will be discussed in more detail in the next quarterly update.

9. Training and Exercising

9.2 Table Top Exercise Feedback – VHK ED Major Incident / Mass Casualty Surge Exercise 22 November 2023

CB advised that in August 2022 a live play decontamination exercise was carried out at Victoria Hospital, Kirkcaldy. SAS made the first contact of notification of major incident then proceeded to testing of category 1 response within hospital setting. The second stage of the exercise was declaration of a major incident with mass casualties.

9.3 Resilience Events Brief Regional

CB advised he will circulate to colleagues.

10. Any Other Business
None

11. Date of next meeting: 13th March 2024

Schedule of Meetings for 2024

13 June 2024 at 1430hrs
11 September 2024 at 1430hrs
12 December 2024 at 1430hrs