ANNUAL STATEMENT OF ASSURANCE FOR THE CLINICAL GOVERNANCE COMMITTEE 2024/25

1. Purpose

1.1 To provide the Board with the assurance 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, includes related activities around planning, maintaining and improving quality.

2. Membership

2.1 During the financial year to 31 March 2025, membership of the Clinical Governance Committee comprised: -

Arlene Wood	Chair / Non-Executive Member
Jo Bennett	Non-Executive Member (from August 2024)
Sinead Braiden	Non-Executive Member (to July 2024)
Colin Grieve	Non-Executive Member
Anne Haston	Non-Executive Member
Janette Keenan	Director of Nursing
Aileen Lawrie	Area Clinical Forum Representative (to February 2025)
Kirstie MacDonald	Non-Executive Member & Whistleblowing Champion (to December 2024)
Dr Christopher McKenna	Medical Director
Liam Mackie	Area Partnership Forum Representative (to August 2024)
Lynne Parsons	Interim Area Partnership Forum Representative (from September 2024)
Carol Potter	Chief Executive
Nicola Robertson	Area Clinical Forum Representative (from March 2025)
Dr Joy Tomlinson	Director of Public Health

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Finance & Strategy, Director of Health & Social Care, Director of Digital & Information, Director of Pharmacy & Medicines, Director of Reform & Transformation, 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 and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on eight occasions during the financial year to 31 March 2025, on the undernoted dates:

- 3 May 2024
- 7 May 2024 (Development Session)
- 12 July 2024
- 6 September 2024

- 1 November 2024
- 22 November 2024 (Development Session)
- 17 January 2025
- 7 March 2025

3.2 The meeting attendance schedule is attached at Appendix 1.

4. Business

4.1 In May 2024, the Committee held its first scheduled meeting of the year, reviewing the annual reports from each of the Clinical Governance Committee sub-groups (including the Clinical Governance Oversight Group), to gain assurance that each body had delivered on its delegated business, and approving the Committee's own assurance statement to the Board for 2023/24. The Clinical Governance Oversight Group also brings to each meeting a regular assurance summary to the Committee on its business, to give confidence that the group is fulfilling its remit, scrutinising in depth proposals and reports prior to their consideration at the Board-level Committee, and dealing with emerging issues as appropriate. Further detail on the Oversight Group's activities is given within the Group's own annual assurance statement, reviewed separately by the Committee. The Area Clinical Forum has in the reporting year provided its first annual statement of assurance, which has been helpful initiative in improving the visibility of the Forum and its work, with the Committee supporting further engagement and discussion with clinicians via the Forum on key strategic proposals of the Board.

4.2 A second meeting was held in May 2024, taking the form of a dedicated Development Session for members, with the topic of 'Clinical Governance in Action' being covered in depth by the operational teams in attendance. Members had the opportunity to discuss the principles of clinical governance, reflect on the work and effectiveness of the Clinical Governance Oversight Group and delivery actions of the Clinical Governance Framework, and hear from operational teams in relation to Adverse Events and the Deteriorating Patient Improvement Programme. This was the first of two dedicated Development Sessions throughout the year, allowing members to gain a greater understanding of key topics within the Committee's remit and to receive detailed briefings from clinicians and service leads from a variety of teams. A further Development Session was held in November 2024, exploring the 'Patient Rights (Feedback, Comments, Concerns & Complaints) (Scotland) Directions' and how these impact on the Board's internal feedback mechanisms, building upon the related report considered at the September meeting. Each of these sessions picked up on common themes or areas covered more broadly within the Committee's overall remit and workplan and allowed for greater scrutiny and discussion by members than normal agenda-driven committee meetings can permit in the time allowed.

4.3 During the year, the Committee has received a number of updates concerning the clinical workforce and initiatives underway to enhance recruitment and role development opportunities for staff, thereby ensuring NHS Fife remains able to deliver safe and high quality treatment to the Kingdom's patients whilst minimising unfilled staff vacancies. In September 2024, the development of Advanced Nurse Practitioner roles was discussed, with members noting the requirement for protected non-clinical time being set aside for staff to progress their skills and knowledge and for adequate clinical supervision to be in place to help staff achieve the Four Pillars of Advanced Practice. Due to the complexities of the role, it was noted that the Nursing & Midwifery Council are due to approve recommendations to develop an approach to regulate advanced practice. At the same meeting, a report on the Allied Health Professional Assurance Framework was given to members, noting similar issues with regard to the provision of protected time for learning. To replace the previous Medical Appraisal & Validation Group, a new Medical & Dental Professional Standards Oversight Group has been established, and its

first report was considered by the Committee in November 2024. The Group's remit includes Appraisal and Revalidation; Consultant and speciality doctor job planning; oversight of all aspects of undergraduate and postgraduate medical and dental education; and Medical Workforce strategic planning. Members welcomed the establishment of the Group, noting its minutes and any points of escalation would henceforth come to the Committee, in addition to the Staff Governance Committee.

4.4 In support of the dedicated Cancer Framework launched in 2023, a review of progress against the Years 1 and 2 delivery plans was considered at the November 2024 Committee meeting, for assurance on the effectiveness of actions and milestone targets. Eight overarching commitments have been identified, supported by key actions aligned to each, with the ambition to achieve these by the end of 2025. A refresh of the Framework is intended to extend the life of the strategy beyond 2025. Also in November 2024, the Committee received an update on the development of the rapid cancer diagnostic service and how the success of the model has been evidenced over time. The report summarised an evaluation undertaken by the University of Strathclyde in relation to the pilot, which concluded that the service has both been highly cost-effective and has caused a reduction in patients going down other consultant-led pathways. The important patient benefits of the service were recognised, including the support around navigating pathways, the emotional support provided by staff on a diagnosis, and the work around health inequalities via targeted preventative work within areas of deprivation. In January 2025, significant assurance was taken from the initial evaluation of the effectiveness of the Single Point of Contact hub for cancer patients, noting the plan to quantify the impact of the hub on patients to secure future funding.

4.5 The Committee has had input into the Board's Annual Delivery Plan for 2024/25, which has been aligned to the strategic priorities within the Board's own Population Health & Wellbeing Strategy and Re-form, Transform, Perform (RTP) Portfolio, whilst also addressing the specific requirements of the Scottish Government guidance. In May 2024, the Committee considered a draft submission. Feedback from Scottish Government was considered at the Committee's July 2024 meeting, where it was also noted that there was a limited level of assurance about delivery of all actions due to the continuing challenging financial situation. Review of the last quarter's work in relation to the previous year's plan was considered also in July 2024, with focus on those quality and safety risks that had fallen behind schedule or were not expected to be delivered. Assurance was taken from the fact that outstanding actions would be carried forward, with appropriate reflection in the Committee's performance and risk reports. In September 2024, the Committee took assurance from the fact that the Scottish Government's review process had concluded, feedback had been submitted and the Plan had been formally approved. A performance report on the delivery of the various Quarter 1 improvement actions was considered at the Committee's September meeting. Of the eight actions marked as red (unlikely to complete on time or to meet the intended target), two fell within the remit of the Clinical Governance Committee. These were related to improved complaints handling performance and development of a new outpatients specialist gynaecology unit, and detail was provided on the work in train to deliver both at an extended timescale. The Quarter 2 update was considered at the November 2024 meeting. 10 actions had fallen behind their target delivery at the point of reporting, but the Committee took assurance from the fact that risks from non-delivery of these programmes of work would be captured in local risk registers and escalated to the Committee as appropriate. The Quarter 3 report received scrutiny at the Committee's March 2025 meeting, with a focus on the actions within the 'Improving Quality & Care' workstreams, with further information to be added on rheumatology transformation before consideration of the report at the Board.

4.6 The Board's RTP portfolio of work introduced in 2024/25 aims to make the changes needed to maintain patient safety and quality of care, in line with the Board's values, whilst managing financial challenges. In May 2024, the Committee received an update on the 13 planned

schemes and the measures in place to ensure that quality and safety of services would be protected. In September 2024, details on Phase 1 of the Acute Services Redesign Programme was considered by members, noting the work to prioritise three areas, namely the formation of an Integrated Acute Respiratory Unit, establishment of a Same Day Emergency Care model, and the redesign of surgical admissions pathways. Assurance was taken from the fact that the process has been clinically driven and multi-disciplinary, with quality indicators to be closely monitored through the change process. Within the September 2024 private session of the Committee, members considered the initial approach for transforming urgent care services, taking assurance from the consideration given to quality and safety matters and endorsing the planned communication and engagement plan with local communities.

4.7 As part of the organisational strategy development, a Clinical Governance Strategic Framework and Delivery Plan was originally approved in 2023, which is fundamental to the Board's aim to be an organisation that listens, learns and improves on a continuous basis. The Framework outlines the key clinical governance activities linked to the attainment of the Board's strategic ambitions and the enablers put in place to ensure effective delivery. The supporting governance structures underneath the Clinical Governance Committee, to ensure operationally effective scrutiny of performance with meaningful measures in place to assess quality and safety of services, is detailed fully in the Framework, and the Committee has had input to ensure that routes of escalation to itself as the key governance body are clear and unambiguous. In July 2024, the Delivery Plan for 2024/25 activities in support of implementation of the Framework was reviewed by the Committee, detailing the timings of each strand of work. The Clinical Governance Oversight Group has supported the regular review and scrutiny of these actions, supported by mid- and year-end reporting to the Clinical Governance Committee. In November 2024, the mid-year report confirmed the high-level status of the 11 workstreams within the delivery plan for 2024/24. Highlights included the work completed in relation to staff support in relation to adverse events, and this was also linked to the Duty of Candour workstream. A refresh of the Framework commenced in September 2024, involving a range of engagement activities across the organisation.

4.8 A new assurance summary from the Mental Health Oversight Group has been added to the Committee's regular business, to support improved visibility of the work underway in this area to enhance services, alongside regular performance metrics. Members considered the first report in January 2025, with a focus on the quality and safety aspects of the actions underway to manage demand, detailing as part of the report new service flash card reporting. Information on the development of a revised Mental Health Strategy and redesign of services to address estates-related requirements was welcomed by members, noting that the content of assurance reports will evolve as the Group continues its work. A further update was considered in March 2025, with members noting the plans in place to ensure that there is joint governance and oversight, in partnership with Health & Social Care colleagues, for the new Mental Health Strategy currently in the final stages of development.

4.9 The draft Corporate Objectives 2024/25 were presented to the Committee in July 2024. The objectives as a whole describe what NHS Fife aims to achieve in-year, and are linked also to the Chief Executive's own objectives and those of each Executive Director. Assurance was provided that there was appropriate linkage to the Board's Population Health & Wellbeing Strategy and to the Health & Social Care Partnership's strategic priorities, in addition to the current Re-form, Transform, Perform portfolio programme. The objectives are framed under the four key strategic priorities of the Board, as aligned to national programmes, and reference the strategy delivery work undertaken in this reporting year. Each Board Committee has had a role in reviewing the objective from their own specific perspective. Following review, the Committee were pleased to endorse the Corporative Objectives for onward submission to the Board for formal approval.

4.10 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints responses and the number of Adverse Events, via the Integrated Performance & Quality Report (IPQR). A dedicated report on Healthcare Associated Infection (HAIs) is also provided on a quarterly basis, to give assurance around the effectiveness of infection prevention, control and surveillance. Following a Board-wide review of the IPQR, reflecting the establishment of the Public Health & Wellbeing Committee and a stand-alone IPRQ review, a set of performance-related metrics specific to the Committee has been refined, to allow for appropriate, regular scrutiny of these at each meeting. The Committee has during the reporting year taken responsibility for scrutiny of a number of metrics around mental health performance related to the quality and safety aspects, such as incidents of unwanted behaviours, ligature and self-harm. Also included, from January 2025, has been data on the stroke care bundle, with an annual report to follow in the next year to improve oversight in this area. Further enhancements have also been made to provide information on corporate risks within the IPQR, aligned to the various improvement outcomes.

4.11 In addition to the IPQR, a number of stand-alone updates on areas of operational performance have been given to the Committee, to provide further context to the cyclical data given in the regular performance reporting. In July 2024, members received an initial update on the current process for adverse events reviews in relation to drugs-related deaths, noting the multi-disciplinary approach to ensure that lessons learned are rolled out across agencies. A more detailed paper was considered by the Committee in November 2024, detailing a new improvement plan for the adverse events process, to bring this in line with the trigger list developed by Healthcare Improvement Scotland. The Committee took a moderate level of assurance from the early stages of delivery, commending the approach to create effective structures and governance to allow learning in a professional and collaborative way, and welcomed further detail from the Clinical Governance Oversight Group in their January 2025 report in relation the implementation of the new approach, as also detailed within the IPQR summary. A briefing on drugs-death cluster reviews was also reviewed in January, in support of a more detailed paper considered at the Public Health & Wellbeing Committee the same month, and this gave further assurance around the management of case reviews across multi-agencies and the preventative work being undertaken across the whole system.

4.12 The Fife Winter Preparedness Plan for 2024/25 was considered by members at the January 2025 meeting, noting this had been jointly prepared by NHS Fife and Fife Health & Social Care Partnership, structured around the four priorities set by Government. The plan outlined how quality and care would be maintained, despite significant service pressure during the winter period. Detail was given on the commitments made to allow both urgent care and GP services protected time to prepare for the winter months, the cost of surge capacity and overall impact on the Board's financial performance, and efforts in place to mobilise the workforce to ensure appropriate staffing was in place. The Committee warmly welcomed the strong commitment from teams to work collaboratively to address the service pressure challenges during winter and took a moderate level of assurance from the actions detailed within the Plan.

4.13 In September 2024, members received a detailed update on the Deteriorating Patient Improvement Project, which aims to address an increase since 2020 in the number of patients experiencing cardiac arrest (which is one of the measures used to track deteriorating patients). The project brings together work underway locally to enhance the observation of patients, linkages to realistic medicine and conversations with patients about their end-of-life care, and alignment with the recommendations of the Scottish Patient Safety Programme. Members have welcomed the information given to the Committee on this important work (reflected also in the Clinical Governance Strategic Framework mid-year report in November 2024), noting the importance of measurement and analysis of actions, as the work progresses into 2025/26.

4.14 In November 2024, the Committee considered the findings of a recent Orthopaedic Hip Fracture Audit, undertaken since NHS Fife had been an outlier against the Scottish mean figure, for the fifth consecutive year, for length of time to theatre for patients presenting with a hip fracture. Extensive review had been undertaken of the current trauma pathways and the recommendations therefrom are being followed up to enhance theatre efficiency, improve access to emergency trauma theatre capacity, balance the demand for emergency vs elective treatment, and look at ways to create further capacity within the system. Members expressed some concern about the prioritisation of orthopaedic trauma and the impact upon equitable treatment, given instances of hip fracture occur most frequently in the older population and that mortality can increase following delay in treatment. In January 2025, the Committee's briefing addressed queries raised by members in earlier discussions, giving further detail on the improvement work planned. Further detail has been requested on mortality themes, and further consideration is to be taken of fragility fracture prevention in the Board's messaging and educational communications. A further brief, including an action plan to address the full detail of the recent internal audit, will be considered by the Committee in May 2025, with the March 2025 committee meeting noting that further discussion if first required at the Executive Directors' Group to review operational issues.

4.15 In March 2025, members considered a report describing the clinical outcomes of closed loop system insulin therapy and members supported the reasons to continue to invest in the technology for patients, noting the cost pressures of doing so. It was recognised that the introduction of this technology, as an early intervention measure for diabetic patients in the short / medium term, provides a significant reduction in longer-term consequences associated with the condition. Members welcomed the further detail provided in the paper, and took assurance from the measures in place to manage the demand against strict criteria. Also in March, a detailed report provided assurance on NHS Scotland's Excellence in Care Programme and Quality of Care Review process, initiatives designed to continuously improve patient care standards, noting the timeframe for implementation in Fife.

4.16 Stand-alone updates on complaints performance / patient experience and feedback have also been discussed at the Committee, noting that the backdrop of an increase in complaints as treatment delays increased after the pandemic continue to influence recovery performance. Enhancements in reporting to the Committee have been introduced, to provide more meaningful data around patient feedback, including further levels of detail around the introduction of an internal complexity categorisation tool to triage and identify those most complex to deliver against timescale and ensure that patients are given realistic information on likely response times. Operational pressures on clinical staff continue to impact heavily on the investigation and sign-off of individual complaint responses. In May 2024, the Committee heard detail on the many positive stories submitted by patients via Care Opinion and the importance of the tool to staff for direct patient feedback. Linkages between thematic categorisation of complaints and work to enhance organisational learning processes were also discussed. The report and action plan from a recent Scottish Public Services Ombudsman investigation was considered also at the May 2024 meeting, with scrutiny of progress in meetings the actions being undertaken via the Clinical Governance Oversight Group. The report in July 2024 noted the effectiveness of the new patient experience dashboard, complexity scoring tool and weekly reporting tool in providing a deeper level of detail of cases, to help services manage the complaints process. In September 2024, the Committee considered the Care Opinion Annual Report, noting the positive stories from patients on NHS Fife services and areas for action. In January 2025, an improved position for Stage 1 complaints was discussed, with a recent focus on timely communication with patients, with continued work to improve the Stage 2 position, including automation of some overly bureaucratic actions in Datix.

4.17 The patient voice has been captured in presentation to each meeting of the Committee patient stories, allowing members to reflect on individual patient experience as part of the Committee's

overall schedule of business. In May 2024, members considered the impact of a patient's ectopic pregnancy, wherein was highlighted the work around deteriorating patients and the importance of a rapid response. At the following meeting, in July 2024, a patient's story in relation to the subject of organ donation was explored. In September 2024, members heard detail about the power of an apology to resolve a complaint, whereas, in November 2024, a patient story in relation to the autism assessment pathway was considered. In March 2025, members heard detail of the important work done by peer supporters in the area of breastfeeding. Each of these stories have highlighted examples of good practice or helped identify areas where we need to improve the quality of services and transform patient and carer experience, through listening and learning from the patient voice.

4.18 The final Organisational Duty of Candour 2023/24 report, outlining the Board's compliance with the relevant legislation and detailing the number of cases that had triggered Duty of Candour processes for the period ending March 2024, was tabled to the Committee at its March 2025 meeting, prior to its formal approval by the Board. There were 29 adverse events detailed within the report, with the most common outcome (for 17 patients) being an increase in their treatment. It has been agreed that Boards should seek to report on Duty of Candour each January, capturing the data from the previous financial year. In addition to the historic data, the Committee heard that currently for 2024/25 there are 4 confirmed adverse events. The Committee took assurance from the learning processes in place to reflect on each adverse event, as discussed frequently throughout the year in relation to the overall adverse events process.

4.19 The Committee receives detailed reports and action plans arising from any regulatory inspection or external investigation, to ensure that learning take places. During the year, a Healthcare Improvement Scotland (HIS) review has been undertaken on the subject of neonatal mortality, with detailed discussion on its conclusions at the September 2024 meeting. In support, a local review of births during 2022 was initially considered by the Committee at its July 2024 meeting, noting the conclusions that NHS Fife's data was in line, or lower than, the average of similar sized Board areas. The Board's response to the findings of the HIS report was considered in September 2024, with the Committee able to take a moderate level of assurance from the work underway to implement the recommendations locally, noting the linkages to adverse events reviews and quality controls for grading outcomes. In November 2024, members discussed the proposed new model for East Region Neonatal Services, reflecting the conclusions of a May 2024 Scottish Government-commissioned report on the Demand and Capacity Modelling of Neonatal ICU services. Concerns were raised about the accuracy of the data on which the modelling exercise had been based on, in addition to other assumptions within. The Committee welcomed the decision that further strategic planning work be undertaken to enable a safe, effective and efficient level of capacity, supported by the correct establishment level of staffing. The Committee were supportive of further work being undertaken at a national level, the result of which was support for the current status quo to be maintained and a full understanding created to mitigate any unintended consequences of a change to the current model on the wider neonatal intensive care facility within Fife. In July 2024, the report on a recent Healthcare Improvement Scotland inspection of the Board's nuclear medicine facilities was considered. The Ionising Radiation (Medical Exposure) Regulations Inspection Report 2024 noted that the facilities assessed were of extremely high quality and the general conclusions were positive. Detail was given on the two recommendations within the report and the governance route for ensuring these are addressed in a robust and timely manner. The Clinical Governance Oversight Group has, throughout the year, reviewed the findings of regulatory investigations in other Boards, as described in the Group's assurance report to the Committee in November 2024. Learning from Mental Welfare Commission investigations are being reviewed through the Organisational Learning Group, with a view to cascading actions through Senior Leadership teams in both Acute and the Health & Social Care Partnership.

4.20 A Safe Delivery of Care Inspection was undertaken by HIS in the Victoria Hospital in December 2024, in follow up to an unannounced inspection undertaken in July to August 2023, as detailed in last year's Committee's assurance report. A verbal update on the inspection was provided at the Committee's January 2025 meeting, in advance of the report being published in March 2025. This follow-up inspection resulted in nine areas of good practice being identified, one recommendation and 13 requirements for the Board to implement. Further detail on the Board's action plan to address the report's findings will be considered at the Committee's May 2025 meeting.

4.21 The Committee considers new and emergent issues at each meeting, seeking assurance around any actions underway to mitigate risks and to ensure patient and staff safety. In January 2024, the Committee originally received a detailed assurance report highlighting that the risk to patients, staff and visitors from the presence of Reinforced Autoclaved Aerated Concrete (RAAC) identified for further assessment within the NHS Fife estate was being fully mitigated against, noting that any potential building areas requiring further investigation were not in high footfall areas or are generally accessible, and would be subject to ongoing condition monitoring and inspection. A follow-up report was received by the Committee in September 2024, detailing the final survey results undertaken across the full estate. In addition to the seven blocks originally identified where RAAC was present, two additional areas were subsequently discovered. Assurance was given that there remained no risk to patients and existing service continuity plans were addressing any other risk aspects. In September 2024, under the topic of emergent issues, the Committee also received a briefing on the backlog of alcohol and drug death reviews within Fife, and plans in place to improve the resources available across multiple agencies to recover the position.

4.22 After initial consideration by the Board's Audit & Risk Committee, the Committee considered the findings of the annual Internal Audit Report 2023/24, with particular reference to the section on Clinical Governance matters. Progress and improvements in this area were warmly welcomed by members, noting the largely positive opinion of the Chief Internal Auditor on the Board's internal control framework, including those controls around quality of care and management of risk. The specific clinical governance elements of the report have been cross-referenced with the Committee's own workplan and that of the Clinical Governance Oversight Group, to ensure all clinical governance actions are incorporated in the work of both groups over the reporting year. The Committee also had sight of the Internal Controls Evaluation report from Internal Audit, providing information on the mid-year position, at their January 2025 meeting. The report contained a full review of all areas of governance, including Clinical Governance, and sought to provide early warning of any issues that might impact the Board's governance statement and would need to be addressed by year-end. There were two recommendations relative to Clinical Governance, the first in relation to enhancing the process of the delivery plan for the Clinical Governance Strategy Framework and the second referencing review of workplans and remits of the Oversight Group and the Committee itself, to ensure no duplication in reporting and to ensure priorities are clear in focussed agendas. These actions have been completed by year end.

4.23 In September 2024, the Committee considered an update report on Medical Devices, reflecting the national guidance that has widened the definition of medical devices to include a broad range of instruments, apparatus, appliances, software, materials and other articles used in the process of delivering healthcare. A clinically-led Medical Devices Group was established in 2023, to support the national changes and to implement the related Scan for Safety programme in Fife, and the Committee were pleased to take assurance from the processes being followed, as described in the briefing. Any matters of escalation will be reported directly to the Committee. In September 2024, members also took assurance from the local measures and governance groups put in place to implement the Scottish Healthcare Associated Infection

Strategy for 2023 to 2025 and the Infection Protection Workforce Strategic Plan, each supporting the reduction of healthcare-associated infections and supporting the quality and safety of patient care.

4.24 Annual reports were received on the subjects of: Adult Support & Protection (submission delayed to May 2025); Radiation Protection; the work of the Clinical Advisory Panel in managing exceptional, high cost and very specialist referrals; the Director of Public Health Annual Report 2023; Fife Child Protection 2023/24; Medicines Safety Review and Improvement; Medical Education; Medical Appraisal & Revalidation; Infection Prevention & Control; Management of Controlled Drugs; Hospital Standardised Mortality Ratio; Research, Innovation & Knowledge Strategy Review; and the Research, Innovation & Knowledge Annual Report. Two internal audit reports have also been reviewed by the Committee for assurance purposes, namely a report on Transport of Medicines and another on Medicines Assurance Audit Programme Short Life Working Group.

4.25 The Committee has received minutes and assurance reports from its core sub-groups, namely the Clinical Governance Oversight Group, Digital & Information Board, Health & Safety Sub-Committee, the Information Governance & Security Steering Group and Resilience Forum, detailing their business during the reporting year. As agreed previously, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's May 2025 meeting.

4.26 In reference to the Health & Safety Sub-Committee, the annual assurance statement from the group provided further detail on efforts to improve staff-side attendance at meetings, the key areas of focus and risks managed by the group during the reporting period. Business considered during the year included redesign of manual handling training provision, with a resulting high compliance rate of 93% against the Scottish Manual Handling Passport successfully achieved within NHS Fife; the creation of a dedicated MS Teams channel to provide peer-to-peer support for managers trained in health and safety and those trained in face fit testing; the recruitment of a new Violence & Aggression Physical Interventions Trainer, to standardise techniques across services, including mental health; and ongoing face fit refresher testing for staff. In relation to risk management, sharp incidents are reported regularly through local performance reporting routes, including to the Local Partnership Fora, and are the subject of regular audits. There has been no further degradation of the previously identified Reinforced autoclaved aerated concrete on the NHS Fife estate, and it remains in the same condition as it did one year ago, with no signs of water ingress or further decomposition. Therefore, as a result, there is no additional risk to patients, staff or visitors. There was no Health & Safety Executive enforcement undertaken during the year within NHS Fife. Noting the detail of the Health & Safety Sub-Committee's activities, the Clinical Governance Committee can take broad assurance from the work undertaken on its behalf during the reporting year.

4.27 The Digital & Information (D&I) Board has continued to develop the governance, process and controls necessary to assure the organisation about the progress of the Digital & Information Strategy 2019 to 2024, which is now in its last year of delivery. Linkages between this and the Population Health & Wellbeing Strategy and the Health Board's Annual Delivery Plan has also been considered. In September 2024, the Committee considered an update on the planned refresh of the Strategy, noting that a short-term digital framework has instead been adopted, as agreed by the D&I Board and defined within the Corporate Objectives. The purpose of the framework is to improve alignment with the developing RTP portfolio of work and the proposals within the Medium-Term Financial Plan. The features of the framework sit within the associated D&I corporate risk, updates on which are detailed in Section 6. The Committee was pleased to endorse the report to the Board, to formally record the completion of the original Strategy and

the next steps aligned to broader strategic aims. In November 2024, members considered a briefing on the development of the new digital framework being established for 2025-28, detailing new emerging requirements in the areas of modernising the patient journey, informatics technology and infrastructure, workforce and business systems.

4.28 The annual Assurance Statement of the Digital & Information Board provides further detail on the Group's activities across the year, as considered by the Committee at its May 2025 meeting. During 2024/25, of the 51 risks routinely monitored by the D&I Board, 15 risks had improved their rating, 12 moved to the target risk rating and to a status of monitor, and 17 risks were closed during the period. In relation to other workstreams considered by the Group, members were updated and took assurance from the learning and action plans undertaken following the NHS Dumfries & Galloway Cyber Incident, subsequently escalated to the Clinical Governance Committee in November 2024. In July 2024, the Board approved a revised and documented approach for the management of digital devices and equipment provided to users and services, to enhance the grip and control measures necessary to support a reduction in spending, through the recovery of unused or additional digital equipment and the redistribution of equipment to offset cost spending. The D&I Board has had initial input into the final review of NHS Fife's Digital Strategy 2019-2024 and the new Digital Framework, both of which have been considered by the Committee directly. In operational matters, the group has received updates on the pilot of an electronic observation monitoring project, which integrates medical devices into PatientTrak for two ward areas, and implementation of waiting list validation functionality that will allow patients to interact with a digital hub. Quarterly updates on D&I performance metrics have also been scrutinised, along with regular updates on key strategic projects, such as Digital Medicines, eRostering, Laboratory Information Management System and the Electronic Health Record. No significant issues have been escalated for disclosure in the Governance Statement and the Clinical Governance Committee can take broad assurance from the work undertaken by the Digital & Information Board over 2024/25.

4.29 Members noted a separate update on the implementation of Hospital Electronic Prescribing and Medicines Administration (HEPMA), via a standalone report to the Committee's September 2024 meeting. Noting that HEPMA has been renamed to Digital Medicines Programme, to reflect the three distinct areas of HEPMA, pharmacy stock control and electronic discharge documentation, supplier and delivery issues were highlighted to the Committee. Risk mitigation was also detailed. In November 2024, the Committee took moderate assurance from a comprehensive briefing provided detailing NHS Fife's response to a ransomware cyber incident impacting NHS Dumfries & Galloway, noting the continuing approach of communication, education and awareness to staff to reduce the likelihood of unauthorised access to confidential data within Fife. Noting that the focus was on ensuring current systems remain reliable and secure, members nevertheless noted the ongoing risk of cyber-attack across large scale organisations.

4.30 The Clinical Governance Committee has also considered updates from the Information Governance & Security Steering Group. The Group has reviewed reports (in September 2024 and March 2025) detailing the current baseline of performance and controls within the remit of Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement in data availability and reporting is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. Assurance was provided that the Group's work aligns appropriately to the Information Commissioner's Office audit and the Board's commitment to the public sector cyber assurance framework, as audited by NES annually. In relation to the latter, an improved outcome for this year's audit was highlighted. An overview was provided on key priorities, which are aligned to the current risk profile. In September 2024, the Committee also considered a stand-alone paper outlining the action plan to address findings from the investigation undertaken after a security breach at St Andrews Community Hospital (as

detailed in last year's report and highlighted as a disclosure in the Board Annual Accounts for 2023/24). Linkages to overall mandatory training compliance was highlighted, but the Committee took a moderate level of assurance from the then-completion of outstanding actions to reduce the likelihood of such an incident recurring.

4.31 The Steering Group has exercised regular scrutiny across the ten categories outlined in the Information Governance & Security Accountability and Assurance Framework, as outlined further in their annual report to the Committee. As such, at March 2025, an improved level of assurance was being reported from the Group. Across the year, the Group have adopted a set of performance measures and a defined workplan, with projects and deliverables associated across outcomes per quarter. This, in turn, brings assurance to support a strong baseline of performance in the area of Information Governance & Security, with improvement against key controls to better measure performance. Key measures reviewed throughout the year included: monthly Subject Access Request data; point-in-time Information Asset Register figures; Information Governance training compliance tracked through the year; monthly Freedom of Information request compliance performance; current policy and procedure review information; Cyber Resilience Framework compliance at the time of audit; monthly event reporting; and summary information on reportable incidents to either the Information Commissioner's Office (ICO) or Competent Authority. Standalone reports on the Records Management project and emerging risks around the GP IT system supplier administration process and improvement work identified as necessary for the Community Electronic Patient Records System, Morse, were also scrutinised. The Network & Information System (NIS) audit cycle report outlined an improvement to 93% total compliance over the reporting year, an increase of 16% from the 2023 report, which was commended by the Group.

4.32 Throughout the year, the Information Governance & Security Steering Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Unlike previous years, the Steering Group saw the complete listing of Digital and Information risks, in a more comprehensive risk report, which mirrored the approach taken with the Digital & Information Board. Visualisation of the risk profile, which averaged 51 in number in the year (as detailed further in 4.28 above), supported the critique and assurance the Steering Group were able to offer.

4.33 There was one outstanding personal data-related incident / data protection breach from Financial Year 2022/23 concluded in this reporting year. The Information Commissioner's Office (ICO) issued a Reprimand to the Board for an incident that occurred in February 2023, in which an unauthorised person gained access to a ward at St Andrews Community Hospital. This has been reported in depth to the Clinical Governance Committee and was subsequently categorised as a disclosure in the Board's Annual Accounts for 2023/24. An update on all actions undertaken by the Board in response to the Reprimand was submitted to the ICO in June 2024 and confirmation was subsequently received from the ICO that the case was closed.

4.34 For Financial Year 2024/25, there was a total of 14 incidents (an increase on the 12 last year) reported to the competent authorities, the ICO and/or the Scottish Government. Three incidents were reported to the Scottish Government only, as they fell under Network & Information Systems reporting obligations. There was one incident, reported January 2025, which, after investigation, was subsequently found not to meet the threshold for reporting (which the ICO has confirmed). There have been seven breaches reported between January and March 2025 and, at the time of writing, we await a response from the ICO regarding four of these. The ICO have confirmed they are taking no further action on all other incidents.

4.35 To support reporting around resilience and emergency planning, the Committee has received an annual assurance statement from the Resilience Forum, to provide members with greater

detail around the further development of business continuity planning within NHS Fife. The Civil Contingencies Act and supporting regulations require NHS Fife to have an established and clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Resilience Forum has led and supported key areas of activity, risk mitigation and strategic development and reporting to ensure preparedness across NHS Fife. The Resilience Forum's annual statement concludes that assurance can be given to the Committee on the areas under its remit, reflecting the work-in-progress underway to strengthen arrangements for resilience planning, business continuity and CONTEST portfolios across NHS Fife and with its contracted partners. These various workstreams are detailed in the annual report, including review of the Incident Management Framework; the enhancements provided via a Business Continuity Management System, including the launch of a new dashboard utilising information from Datix; data on the Business Continuity Plan Testing, Training and Exercises undertaken over the last year, including those with external agencies; and details of training and awareness raising delivered to staff. Work has been undertaken to fully address the recommendation of two recent internal audit reports on business continuity arrangements, which have been subject to separate reporting to the Audit & Risk Committee, with the action plans resulting therefrom monitored via existing Audit Follow Up protocols. The Board has been able to improve its compliance against NHS Scotland's core standards for Emergency Preparedness, Resilience & Response (EPRR) and is now substantially compliant with the standards. The Committee can take assurance that work will continue over the year ahead to further develop an annual EPRR work programme with key partners in primary, secondary & acute care service areas.

4.36 The Clinical Governance Oversight Group has brought its year-end reporting into line with the other sub-groups and its 2024/25 annual statement was considered by the Committee at the May 2025 meeting. The report has provided assurance on the Group's activities, principally its operational oversight of the quality and safety of care provided across the Fife health system and how this impacts on the patient / user experience. The Group has extended its membership in the reporting year, to include enhanced representation from Acute, Health & Social Care Partnership, Medical Education and Digital Information, seeking to advance the clinical governance agenda. The Group has also maintained an awareness of evolving quality, safety and governance agendas, both internal and external to NHS Fife, and has had a role in identifying key learning points from a range of activities, ensuring these are communicated and embedded where appropriate across primary and secondary care and the Health & Social Care Partnership. Regular reports outlining performance and improvement actions in areas such as patient experience, organisational learning, and escalation reporting from Acute and Health & Social Care Partnership clinical governance groups. The Group maintains rolling supervision of clinical policy update compliance and performance monitoring, particularly with regard to the timely completion of adverse event reviews, Children and Young Persons' Death Review (the subject of a separate report to the Committee in September 2024) and Duty of Candour processes. The Clinical Governance Committee was able to take robust assurance from the supporting clinical governance activities carried out by the Group over the course of the reporting year.

4.37 An annual statement of assurance has also been received and considered from the Quality & Communities Committee of the Integration Joint Board (IJB). This report aims to provide assurance to the IJB that adequate governance arrangements relating to the Quality & Communities Committee are in place, allowing the IJB to discharge its duties in line with the Good Governance Framework, and it is subsequently shared with NHS Fife for similar assurance purposes. The format of the report has been changed this year, to list all business transacted as an appendix, in preference to a textual report reflecting on the assurance provided by the Committee's work.

4.38 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives an Assurance Report at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates. A rolling update on the workplan is presented to each meeting, for members to gain assurance that reports are being delivered on a timely basis and according to the overall schedule. A final version of the workplan for 2025/26 was approved at the Committee's March 2025 meeting.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2024/25.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of its aligned risks assigned to it under the Corporate Risk Register. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to active and emerging issues have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care and service delivery, particularly during challenging periods of activity.

6.2 Regular review of the Corporate Risk Register has allowed for revision of the key strategic risks reported to the Board, along with presentation improvements to aid clarity of members' understanding. As the Corporate Risk Register has become embedded, improvements have continued to be made to reflect members' feedback. Deep dives have allowed for greater scrutiny of the root causes of risks and discussion on the effectiveness of management actions in place to reduce risk levels. Linkages to the Board's overall risk appetite have been discussed with members, noting that for those individual metrics currently facing a risk profile in excess of the Board's agreed appetite, a degree of tolerance has been agreed, given the scale of external challenges facing the Board. The Board has reassessed its risk appetite as a whole during sessions in April and November 2024, and this is reflected in ongoing updates to the individual risk metrics.

6.3 During the year, in relation to Quality & Safety matters, the Committee has reviewed a refresh of the dedicated risk around Optimal Clinical Outcomes, following detailed discussion at the Risk & Opportunities Group. This was initially written to be relatively broad in its coverage and thus members have undertaken a deep dive into the risk, to seek to understand the make-up of the risk and the drivers that influence its rating. It has been agreed that the risk requires more focus, A subsequent Development Session has helped refine this risk further, both to reflect members' queries and to aid understanding. A further review was taken in July and September 2024, detailing the aspects of the risk mitigation actions that were on track and those that were experiencing challenge, with further review on the fundamentals of this risk undertaken via the Risk & Opportunities Group. This has sought to consider how effective the larger programmes of work are in mitigating the risk and how some of the Board's performance metrics, such as waiting times, impact upon patient safety. Additionally, reflecting the Board's agreed Risk Appetite statement has been required. In January 2025, a proposal to replace the Optimal

Clinical Outcomes risk with a new wording related to hospital-acquired harm was discussed by members, and this was recommended to the Board, along with the revision of wording to three corporate risks (to ensure a focus on patient safety and outcome) aligned to the Director of Acute Services. A deep dive on the new risk, and further discussion about how the effectiveness of the mitigation actions would be measured, was undertaken by members in March 2025.

6.4 An update on the Quality & Safety risk has been undertaken during the year, in relation to how the risk can better reflect the Board's approach to Organisational Learning and indicate what assurances the Committee can take from the work of the Organisational Learning Group. This has built upon a full Board Development Session held to discuss Organisational Learning principles. The Committee was pleased to consider a stand-alone update on work to enhance Organisational Learning at its September 2024 meeting, building in feedback from the Board session, noting that 2024/25 has principally been a year to focus on laying the foundations for this important work and ensure broad uptake amongst services.

6.5 The Off-Site Area Sterilisation and Disinfection Unit Service risk, detailing some quality-related concerns with the provision of sterile instrument trays from the current supplier, which has the potential to impact on the safe delivery of critical surgical interventions and procedures, has been reviewed during the year. Members were content to recommend to the Board the removal of this from the Corporate Risk Register, to be henceforth managed as an operational risk, reflecting its day-to-day management by Executive officers. The Board subsequently approved this change, noting that any changes or proposals to off-site sterilisation arrangements would be managed through the RTP programme of work.

6.6 In relation to Digital & Information risks, further detail is provided in Section 4.1 in reference to the supporting work of the Digital & Information Board. The risk review associated with the Corporate Risk 17 (Cyber Resilience) has been given additional consideration by the D&I Board and the Clinical Governance Committee, via the scrutiny of a deep dive of the risk descriptor and the mitigating actions.

7. Self-Assessment

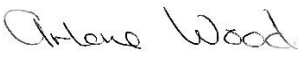
7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2025 meeting, and action points are being taken forward at both Committee and Board level, reflecting a number of common themes across committees. The Committee has held a dedicated Development Session in May 2024 to refresh members' knowledge about the Principles of Clinical Governance and ensure there is appropriate coverage of these through the Committee's own local work.

8. Conclusion

8.1 As Chair of the Clinical Governance Committee, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed:  Date: 22 April 2025

Arlene Wood, Chair, 2023-24
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS Fife Clinical Governance Committee Attendance Record
1 April 2024 to 31 March 2025

	03.05.24	12.07.24	06.09.24	01.11.24	17.01.25	07.03.25
Members						
A Wood, Non-Executive Member **(Chair)**	✓	✓	✓	✓	✓	✓
J Bennett, Non-Executive Member		✓ observing	✓	✓	✓	✓
S Braiden, Non-Executive Member	x	x				
C Grieve, Non-Executive Member	✓	✓	✓	x	✓	✓
A Haston, Non-Executive Member	✓	✓	✓	✓	✓	✓
A Lawrie, Area Clinical Forum Representative	✓	x	x	✓	✓	
K MacDonald, Non-Executive Whistleblowing Champion	✓	x	x	✓		
L Mackie, Area Partnership Forum Representative	✓	x				
C McKenna, Medical Director **(Exec Lead)**	✓	✓	✓	✓	✓	✓
J Keenan, Director of Nursing	✓	✓	✓	✓	✓	✓
L Parsons, Interim Area Partnership Forum Rep			✓	x	✓	✓
C Potter, Chief Executive	✓	x	✓	✓	✓	✓
N Robertson, Area Clinical Forum Representative						✓
J Tomlinson, Director of Public Health	x	✓	x	x	✓	✓
In Attendance						
B Archibald, Planning & Performance Manager						✓ Items 8.1 – 9.1
L Barker, Director of Nursing, Health & Social Care Partnership			x	x	x	x
N Beveridge, Director of Nursing, Acute			x	x	x	x
N Connor, Director of H&SC	✓	x				
G Couser, Associate Director of Quality & Clinical Governance	✓	✓	✓	✓	✓	x
L Cooper, Head of Primary & Preventative Care						✓ deputising
C Dobson, Director of Acute Services	✓	x	✓	✓	x	✓
J Doyle, Head of Nursing			✓ deputising			

APPENDIX 1

	03.05.24	12.07.24	06.09.24	01.11.24	17.01.25	07.03.25
F Forrest, Acting Director of Pharmacy & Medicines	✓	x	✓	✓	✓	✓
S Fraser, Associate Director of Planning & Performance	✓	✓	✓	x	✓	x
L Garvey, Director of Health & Social Care					✓	x
A Graham, Director of Digital & Information	✓	x	✓	✓	✓	✓
B Hannan, Director of Planning & Transformation	✓	✓	✓	✓	✓	x
H Hellewell, Associate Medical Director, H&SCP	✓	✓	✓	✓	x	x
B Hudson, Regional Audit Manager					✓	
P Kilpatrick, Board Chair	✓					
J Lyall, Chief Internal Auditor		✓ Items 1 – 5				
G MacIntosh, Head of Corporate Governance & Board Secretary	✓	✓	✓	✓	✓	✓
I MacLeod, Deputy Medical Director	✓	✓	✓	✓	x	x
N McCormick, Director of Property & Asset Management	x	x	✓	x	x	x
M McGurk, Director of Finance & Strategy	x	x	x	✓	x	x
F McKay, Interim Director of Health & Social Care		✓ deputising	✓	✓		
B Morrison, Interim Area Partnership Forum Representative				✓ deputising		
N Robertson, Director of Nursing, Corporate			✓	✓		
S A Savage, Interim Associate Director of Quality & Clinical Governance / Associate Director of Risk & Professional Standards	✓	x	✓	✓	✓	x
G Simpson, Anaesthetics Consultant			✓ Item 9.5			
M Watts, General Manager, Surgical Directorate					✓	
A Wong, Director of Allied Health Professionals			✓	✓	✓	x

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Annual Delivery Plan Winter Preparedness Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Annual Delivery Plan NHS Fife Clinical Governance Workplan is approved annually and kept up-to-date on a rolling basis Minutes from Linked Committees e.g. • Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • Clinical Governance Oversight Group • Infection Control Committee • H&SCP Quality & Communities Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

Governance and Accountability

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	Ongoing	Strategy updates considered regularly Via the NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports on common template EQIA section on all reports

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system. NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report, in addition to stand-alone reports each quarter.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Regular update on Patient Experience considered by the Committee. NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints and compliments are monitored through the report.

Use of Resources

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife’s activities.	Information & Security Governance Steering Group Annual Report Digital & Information Board Annual Report Digital & Information Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports. Reporting format and content has been enhanced in current year.
NHS Fife understands and exploits the value of the data and information it holds.	Risk Deep Dives Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting. Particular review of performance in relation to pressure ulcers and falls undertaken in current year.

Performance Management

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Operational Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes from Linked Committees e.g. • Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • Digital & Information Board • Infection Control Committee • Information Governance & Security Steering Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format and content is being undertaken in reporting year.
Reports are honest and balanced and subject to	Committee Minutes show scrutiny and challenge when performance	**COMMITTEES**	Every meeting	Integrated Performance & Quality Report considered at

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
proportionate and appropriate scrutiny and challenge from the Board and its Committees.	is poor as well as good; with escalation of issues to the Board as required	**BOARD**		every meetings Minutes of Linked Committees are reported at every meeting, with improved process for escalation of issues.
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with complaints, adverse events.
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes of Linked Committees • Area Clinical Forum • Acute Services Division, Clinical Governance Committee • Area Drugs & Therapeutics Committee

Cross-Cutting Theme – Equality

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered, along with Planning with People updates in current year All strategies have a completed EQIA
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered All strategies have a completed EQIA
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy when uploaded onto the website

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	Update on Participation & Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users